SERFF Tracking Number:	*CEUL-128329220*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*HPACC2010*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*HPACC2010*		
Project Name/Number:	*HPACC2010/HPACC2010*		

Filing at a Glance

Company: Central United Life Insurance Company

Product Name: HPACC2010	SERFF Tr Num: CEUL-128329220	State: Arkansas
TOI: H02I Individual Health - Accident Only	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H02I.000 Health - Accident Only	Co Tr Num: HPACC2010	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Author: Leigh Floyd	Disposition Date: 05/04/2012
	Date Submitted: 05/03/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: HPACC2010	Status of Filing in Domicile: Pending
Project Number: HPACC2010	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 05/04/2012
	State Status Changed: 05/04/2012
Deemer Date:	Created By: Leigh Floyd
Submitted By: Leigh Floyd	Corresponding Filing Tracking Number:

Filing Description:

We are requesting the Department's review and approval of our new Accident policy. There are two versions of the product.

One version provides 24-hour accident coverage. The other version provides accident coverage while off-the-job only.

There are two separate policies, outlines of coverage and rates specific to each version of the product. There is also a Wellness rider that will be marketed with both policies that pays a benefit when an insured recieves a specified wellness exam.

This product is not replacing any previously filed product.

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This product is guaranteed renewable up to age 70; however, this policy is not able to be sold to individuals eligible for Medicare by reason of age. Issuance ends at age 64.

Agents licensed in your state will sell this product to individual consumers. The application and outline of coverage will be used to market the policy.

This product complies with the standards set forth by the NAIC. We have adhered to all state-specific guidelines and the required forms have been attached.

We appreciate the Department's time and consideration in the review of this filing.
State Narrative:

Company and Contact

Filing Contact Information

Leigh Floyd,
10700 Northwest Freeway
Houston, TX 77092

lfloyd@manhattanlife.com
713-529-0045 [Phone] 5271 [Ext]

Filing Company Information

Central United Life Insurance Company
Wortham Tower
2727 Allen Parkway
Suite 500
Houston, TX 77019-2100
(713) 529-0045 ext. [Phone]

CoCode: 61883
Group Code: 117
Group Name:
FEIN Number: 42-0884060

State of Domicile: Arkansas
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$300.00
Retaliatory?	No
Fee Explanation:	3 Forms, 1 application and 2 rates = 6 X $50 = $300.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Central United Life Insurance Company	$300.00	05/03/2012	58911084

SERFF Tracking Number:	*CEUL-128329220*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/04/2012	05/04/2012

SERFF Tracking Number:	*CEUL-128329220*	*State:*	*Arkansas*
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Product Name:	*HPACC2010*		
Project Name/Number:	*HPACC2010/HPACC2010*		

Disposition

Disposition Date: 05/04/2012
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	**Overall % Indicated Change:**	**Overall % Rate Impact:**	**Written Premium Change for this Program:**	**# of Policy Holders Affected for this Program:**	**Written Premium for this Program:**	**Maximum % Change (where required):**	**Minimum % Change (where required):**
Central United Life Insurance Company	%	%	$		$	%	%

SERFF Tracking Number:	*CEUL-128329220*	*State:*	*Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	24 Hour Accident Policy	Approved-Closed	Yes
Form	Non Occupational Accident Policy	Approved-Closed	Yes
Form	Wellness Rider	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Rate	24 Hour Rates	Approved-Closed	Yes
Rate	Non Occupational Rates	Approved-Closed	Yes

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Form Schedule

Lead Form Number: HPACC2010-24-2

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/04/2012	HPACC2010-24-2	Policy/Contract/Fraternal Certificate	24 Hour Accident Policy	Initial		60.100	HPACC2010-24-2.pdf
Approved-Closed 05/04/2012	HPACC2010-NOC-2	Policy/Contract/Fraternal Certificate	Non Occupational Accident Policy	Initial		59.900	HPACC2010-NOC-2.pdf
Approved-Closed 05/04/2012	HRWEL2010	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Wellness Rider	Initial		58.760	HRWEL2010.pdf
Approved-Closed 05/04/2012	C-HPACC-AP 0211	Application/Enrollment Form	Application	Initial			C-HPACC-AP 0211.pdf

CENTRAL UNITED LIFE INSURANCE COMPANY

A Stock Company

[10700 Northwest Freeway
Houston, Texas 77092]
Customer Service: [800-669-9030]

This is a legal contract between the owner of the Policy (You) and Central United Life Insurance Company (Central United). It is issued in return for Your application and first premium. Central United agrees to pay this Policy's Benefits to You if an Insured Person suffers a loss covered under this Policy due to a Covered Accident while this Policy is in effect and the Policy's provisions are met.

RENEWAL PROVISION

You have the right to renew this Policy until age 70 if You pay the correct premium when due or within the Grace Period. If premiums are paid on time, We cannot (prior to age 70) cancel this Policy or place any restrictive rider on it. We reserve the right to change premiums from time to time. If We do change premiums, We will only do so only if: 1) We change the premiums for all policies of this class in Your state; 2) such change is in accordance with the laws and regulations of your state; and 3) We give You 30 days written notice (or longer if required by the state in which this policy is issued) before such change becomes effective.

TEN-DAY FREE LOOK

You may cancel this Policy within 10 days of receiving it. Return the Policy to Central United's Administrative Office or to Your Central United sales agent. As soon as You deliver or mail the Policy to Us, it is treated as if it was never issued. We will refund Your premium payment when We receive the Policy back.

CANCELLATION

After the 10-day free look period, You may cancel this Policy by notifying Us in writing that You wish to do so. Cancellation of Your Policy will be effective on the date We receive Your written notice unless Your notice specifies a later date. We will promptly refund any premium paid for coverage after the cancellation date. Cancellation of this Policy will be without prejudice to any claim made prior to the termination of the contract.

Central United Life Insurance Company has signed this Policy on the Issue Date.

[Mary Lou Rainey
Secretary]

[Dan George
President]

24-HOUR ACCIDENT EXPENSE POLICY
LIMITED BENEFITS
This is an accident only policy which does not pay benefits for a loss from sickness

Guaranteed Renewable to age 70
Company may change Table of Premium Rates

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- Legal Actions

CENTRAL UNITED LIFE INSURANCE COMPANY

[10700 Northwest Freeway
Houston, Texas 77092]

POLICY SCHEDULE

24-HOUR ACCIDENT EXPENSE POLICY

Primary Insured: [John Q. Doe]
Policy Number: [12 345678]
Effective Date: [02/01/2011]
Insured Dependents:
Spouse: [Jane Doe]
[ ]
[ ]
[ ]
[ ]

Issue Age: [52]

Initial Premium $[33.00]
Mode of Payment [Monthly]

FORM #	BENEFIT DESCRIPTION	PREMIUM
[HPACC2010-24]	Guaranteed Renewable to age 70, subject to the Company's Right to Change Premium	
	Accidental Death Benefit Insured	$[23.00]
	Insured $[25,000, 50,000]	
	Spouse $[10,000, 20,000]	
	Child(ren) $[5,000, 10,000]	
	Accidental Death – Common Carrier	Accidental Death Benefit will be doubled.
[HRWEL2010]	[Wellness Rider $60.00]	$[10.00]

DEFINITIONS

AGE: Your Age as of your last birthday.

AMBULANCE: A ground or air vehicle which is licensed as required by law, as an Ambulance, and is equipped to transport sick or injured persons.

CONFINED/CONFINEMENT: An Insured Person's Medically Necessary admission to and subsequent continued stay in a Hospital as an overnight bed patient for which a charge is made for room and board.

COVERED ACCIDENT: An accidental bodily injury that happens to an Insured Person while this Policy is in force.

DENTAL TREATMENT: Treatment of the teeth and/or periodontal area.

DEPENDENT CHILD(REN): Any natural child, step-child, legally adopted child or child placed into Your custody for adoption who is: (a) unmarried; (b) living with You in a regular parent – child relationship; (c) qualified as a dependent of You or Your Spouse for tax purposes according to the United States Internal Revenue Code; and (d) younger than age 26.

EMERGENCY CARE: Those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her injury is of such a nature that failure to obtain immediate medical care could result in:

- placing the patient's health in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

HOSPITAL: An institution operated pursuant to law for the care and treatment of injured and sick persons which:

- maintains (either on its premises, or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians) organized facilities for medical, diagnostic and surgical care for injured and sick persons on an inpatient basis for which a charge is made that the Insured Person is legally obligated to pay;
- maintains a staff of one or more duly licensed Physicians;
- provides 24 hour nursing care by or under the supervision of an R.N.;
- maintains and operates a minimum of 5 beds; and
- maintains permanent medical history records.

Hospital does not include any facility which is used principally as a facility for the aged, drug addicts, alcoholics, custodial care, educational care, rest or convalescence, or care of Mental or Nervous Disorders.

INSURED PERSON: You (primary insured) and Your Spouse and Dependent Child(ren) as listed on the application, and named in the Policy Schedule.

INTENSIVE CARE UNIT: Intensive Care Units are defined as an area or unit of a hospital that is separate and apart from the surgical recovery room and from the general service rooms, beds and wards. It must have 24-hour nursing care attended by nurses assigned on a full-time basis exclusive to such unit; and a stay in the unit must be at the direction and/or supervision of a full-time Physician director or a standing "intensive care" committee of the medical staff. Intensive Care Units include an intensive cardiac care unit and a neo-natal intensive care unit. It does not include: progressive care units; sub-acute intensive care units; intermediate care units; private monitored rooms; observation units; or other lesser treatment units.

ISSUE DATE: The effective date of coverage provided by this Policy. See the Policy Schedule.

MEDICALLY NECESSARY OR MEDICAL NECESSITY: The necessity of a service or supply as appropriate for the diagnosis or treatment of a Covered Accident based on generally accepted current medical practice. A service or supply will not be considered Medically Necessary if:

- it is provided only as a convenience to the Insured Person or provider;
- it is not appropriate treatment for the Insured Person's diagnosis or symptoms; or
- it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

MENTAL OR NERVOUS DISORDER: Any disorder classified as such in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

PHYSICIAN: A licensed medical provider who acts within the scope of his or her license and provides treatment or care necessary for a Covered Accident. The Physician must be someone other than You or a member of Your immediate family.

POLICY: This Accident Expense contract.

POLICY SCHEDULE: Page 3 of this Policy.

RENEWAL PREMIUMS: The amount You must pay Us to keep this Policy in force.

SPOUSE: Your spouse for whom You have applied for insurance coverage under this Policy and for whom premium payments are made. At the time of application, Your spouse must be at least 18 years of age and no more than 69 years of age.

WE, OUR, US, THE COMPANY: Central United Life Insurance Company (Central United).

YOU, YOUR: The Insured/Owner of this Policy. If the Insured is not the Owner, You refers to either as the context allows.

PREMIUMS AND REINSTATEMENT

Premium Payments: The first premium is due on the Issue Date. Premiums will include rider premiums, if any. premiums paid after the first premium are Renewal Premiums. We may change Renewal Premiums. The rules for doing this are on Page 1.

The date Renewal Premiums are due is called the due date. Subject to the Grace Period, Your Policy will end if a Renewal Premium is not paid by the due date. All premiums are payable to Us.

Grace Period: You have a 31-day Grace Period to pay Renewal Premiums. The Grace Period starts on the due date and ends 31 days later. During the Grace Period, Your Policy stays in force. If You do not pay the Renewal Premium by the end of the Grace Period, Your Policy will lapse (end).

Reinstatement: Our acceptance of premium for this policy beyond the grace period will not reinstate the policy. Our only liability will be to return the premium. In order to reinstate the policy, all insureds requesting coverage must complete an application for reinstatement subject to our underwriting guidelines. The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement. In all other respects the Insured and Company shall have the same rights thereunder as they had under this Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

Refund of Unearned Premium: Within 30 days of proof of an Insured Person's death, We will refund any unearned premium paid for such person for any period beyond the end of the month in which death occurred.

Unpaid Premiums: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

BENEFITS

This policy will pay the following benefits for loss resulting from a Covered Accident for each unit purchased:

Accidental Death Benefit. We will pay the benefit amount shown on the Policy Schedule if any Insured Person is injured as the direct result of a Covered Accident. The injury must be the cause of the Insured Person's death and occur within 90 days after the Covered Accident.

Accidental Death – Common Carrier. We will pay the benefit amount shown on the Policy Schedule if any Insured Person is injured as the result of a Covered Accident while a fare-paying passenger on a common carrier operating on a regularly scheduled basis such as a plane, bus or train. The injury must be the cause of the Insured Person's death and occur within 90 days after the Covered Accident. If We pay this benefit, the Accidental Death Benefit will not be paid.

Burn. We will pay the applicable amount listed below if any Insured Person receives burns as the result of a Covered Accident which are treated by a Physician within 72 hours after the Covered Accident. We will pay only one benefit amount per Covered Accident.

We will pay 25% of the applicable Burn Benefit if any Insured Person receives a skin graft for a burn for which a benefit was paid under the Burn Benefit of this policy. This benefit will be payable only once per Covered Accident.

	You	**Spouse/Child**
Second degree burns which cover at least 36% of the body surface	$ 375	$ 150
Third degree burns which cover at least 1% of the body surface but less than 20% of the body surface	$ 750	$ 300
Third degree burns which cover 20% or more of the body surface	$5,000	$2,000

Dislocated (separated) Joint. We will pay the applicable amount listed below if any Insured Person receives a dislocation as the result of a Covered Accident. As this list is not complete, We will pay a benefit similar to the dislocation suffered if not listed. A dislocation is a completely separated joint. In order for this benefit to be payable for the joint involved, all of the following must occur:

- it must be diagnosed as a dislocation by a Physician within 90 days after the Covered Accident;
- the dislocation must require correction with anesthesia by a Physician; and
- the dislocation will be corrected by open (surgical) or closed (non-surgical) reduction.

If any Insured Person receives more than one dislocation in a Covered Accident and requires open or closed reduction, We will pay for all dislocations. However, We will pay no more than two times the amount for the joint involved which has the highest benefit amount.

If the dislocation requires reduction without anesthesia by a Physician, We will pay 25% of the amount listed for a closed reduction of the joint involved.

If a Physician diagnoses the dislocation as an incomplete dislocation, We will pay 25% of the amount listed for a closed reduction of the joint involved. An incomplete dislocation is a dislocation in which the joint is not completely separated.

We will pay this benefit only for the first dislocation of a joint after the policy Issue Date. Subsequent dislocations of the same joint after the policy Issue Date will not be covered.

Joint	**Closed Reduction**	**Open Reduction**
Hip	$1,000	$2,000
Knee (except Patella)	500	1,000
Ankle	400	800
Bone or bones of the foot (other than toes)	400	800
Collarbone (Sternoclavicular)	250	500
Lower Jaw	150	300
Shoulder (Glenohumeral)	150	300
Elbow	150	300
Wrist	150	300
Bone or bones of the hand (other than fingers)	150	300
Collarbone (Acromioclavicular and separation)	50	100
One toe or finger	50	100

Emergency Dental Work. We will pay the applicable amount listed below for dental work required by an Insured Person as the result of Injuries received in a Covered Accident.

Any and all broken teeth repaired with crown(s)	$150
Any and all broken teeth resulting in extraction(s)	$ 50

Benefits are payable only once per Covered Accident, regardless of the number of teeth involved.

Fracture (broken bone). We will pay the applicable amount listed below if any Insured Person receives a fracture as the result of a Covered Accident. As this list is not complete, We will pay a benefit similar to the fracture suffered if not listed.

A fracture is a break in a bone which can be seen by X-ray. In order for this benefit to be payable for the bone involved, all of the following must occur:

- it must be diagnosed as a fracture by a Physician within 90 days after the Covered Accident; and
- the fracture must require open (surgical) or closed (non-surgical) reduction by a Physician.

The maximum benefit payable for all fractures as the result of a Covered Accident is equal to two times the amount of the fracture with the highest benefit amount.

If a Physician diagnoses the fracture as a chip fracture, We will pay 25% of the amount listed for the closed reduction for the bone involved. A chip fracture is a fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

Bone	**Closed Reduction**	**Open Reduction**
Skull (except bones of face or nose)		
Depressed skull fracture	$1,250	$2,500
Simple non-depressed skull fracture	500	1,000
Hip, thigh (Femur)	750	1,500
Vertebrae, body of (excluding Vertebral Processes)	400	800
Pelvis (includes Ilium, Ischium, Pubis, Acetabulum except Coccyx)	400	800
Leg (Tibia and/or Fibula)	400	800
Bones of face or nose (except Mandible or Maxilla)	175	350
Upper jaw, Maxilla (except Alveolar Process)	175	350
Upper arm between elbow and shoulder (Humerus)	175	350
Lower jaw, Mandible (except Alveolar Process)	150	300
Shoulder blade (Scapula), collar bone (Clavicle, Sternum)	150	300
Vertebral Processes	150	300
Forearm (radius and/or Ulna)	150	300
Knee cap (Patella)	150	300
Hand, foot (except fingers, toes)	150	300
Ankle, wrist	150	300
Rib	125	250
Coccyx	100	200
Finger, toe	25	50

Hospital Admission. We will pay $500 if any Insured Person is Confined to a Hospital as the result of Injuries received in a Covered Accident. The Insured Person must be Confined within 180 days after the Covered Accident. This benefit will not be paid for:

- Emergency Room treatment;
- outpatient treatment; or
- a stay of less than 20 hours.

This amount will be paid once per Covered Accident.

Hospital Confinement. We will pay $100 per day for up to 90 days per Covered Accident if any Insured Person is Confined in a Hospital or Hospital Sub-Acute Intensive Care Unit as the result of Injuries received in a Covered Accident. The Insured Person must become Confined in a Hospital or a Hospital Sub-Acute Intensive Care Unit within 180 days after the Covered Accident. We will pay benefits for only one Hospital Confinement at a time even if it is caused by more than one Covered Accident. We will not pay this benefit for:

- Emergency Room treatment;
- outpatient treatment; or
- a stay of less than 20 hours.

Hospital Intensive Care Unit Confinement. We will pay $200 per day for up to 15 days per Covered Accident if any Insured Person is Confined to a Hospital Intensive Care Unit as the result of Injuries received in a Covered Accident. The Confinement in a Hospital Intensive Care Unit must begin within 30 days after the Covered Accident.

If any Insured Person is Confined to a Hospital Intensive Care Unit that does not meet the definition in this policy of a Hospital Intensive Care Unit, We will pay the Hospital Confinement Benefit. The Hospital Intensive Care Unit Confinement Benefit and the Hospital Confinement Benefit will not be paid concurrently. If any Insured Person is Confined in a Hospital Intensive Care Unit for more than 15 days, the Hospital Confinement Benefit will begin on the 16th day. The total amount payable per Covered Accident will not exceed 90 days for Hospital Confinement and 15 days for Hospital Intensive Care Unit Confinement.

Knee Cartilage – Torn. We will pay $500, reduced by any benefit paid for arthroscopic surgery previously performed, if any Insured Person receives a torn knee cartilage (meniscus) as the result of a Covered Accident. For this benefit to be paid, all of the following must occur:

- it must be treated by a Physician within 60 days after the Covered Accident; and
- it must be repaired through surgery by a Physician within 180 days after the Covered Accident.

If exploratory arthroscopic surgery is performed within 180 days of the Covered Accident and no repair is done, or if the cartilage is shaved (debridement), We will pay $100.

Laceration. We will pay the applicable amount listed below if any Insured Person receives a laceration as the result of a Covered Accident. The laceration must be repaired by a Physician within 72 hours after the Covered Accident. The amount We will pay is based on the total length of all lacerations received in any one Covered Accident which require repair. If the laceration is severe enough to require stitches but the Physician chooses to repair it in another way, We will pay it as a laceration repaired with stitches.

Total of all lacerations is not more than three inches (7.6 cm) long and repaired by stitches, staples or glue	$50
Total of all lacerations is greater than three and not more than five inches (7.6 cm to 12.5 cm) long and repaired by stitches, staples or glue	$200
Total of all lacerations is more than five inches (12.5 cm) long and repaired by stitches, staples or glue	$400

If any Insured Person receives a laceration on a finger, toe, hand, foot or eye and later loses that finger, toe, hand, foot or eye as the result of the same Covered Accident, We will subtract the amount We paid under the Laceration Benefit from the Loss of Finger, Toe, Hand, Foot or Sight of an Eye Benefit.

Loss of Finger, Toe, Hand, Foot or Sight of an Eye. We will pay the applicable amount listed below for loss received as the result of a Covered Accident and in which loss occurs within 90 days after the Covered Accident.

	You	**Spouse/Child**
Loss of both hands, or both feet, or the sight of both eyes, or any combination of two or more listed above	$15,000	$10,000
Loss of one hand, or one foot, or sight of one eye	$7,500	$5,000
Loss of two or more fingers, or two or more toes, or any combination of two or more listed above	$1,500	$1,000
Loss of one finger or one toe	$750	$500

“Loss of a hand” means that the hand is cut off through or above the wrist joint or the use of the hand is medically determined to be permanently lost. “Loss of a foot” means that the foot is cut off through or above the ankle joint or the use of the foot is medically determined to be permanently lost. “Loss of a finger” means that the finger is cut off at the joint proximate to the first interphalangeal joint where it is attached to the hand. “Loss of a toe” means that the toe is cut off at the joint proximate to the first interphalangeal joint where it is attached to the foot. “Loss of sight of an eye” means that at least 80% of vision is permanently lost.

If the Insured Person loses a finger or toe and later loses a hand or foot within 90 days on the same side of the body as the result of the same Covered Accident, We will subtract the amount paid for the loss of a finger or toe from the Loss of Finger, Toe, Hand, Foot or Sight of an Eye Benefit.

Only the highest single benefit will be payable per Covered Accident. Benefits will be paid only once per Covered Accident. If death and Loss of Finger, Toe, Hand, Foot or Sight of an Eye result from the same Covered Accident, only the Accidental Death Benefit will be paid.

Major Diagnostic Exams. We will pay $100 per Calendar Year if an Insured Person requires one of the following exams for Injuries received as the result of a Covered Accident:

- angiogram;
- CT (computerized tomography) scan;
- CTA (computerized tomography angiogram) scan;
- MRI (magnetic resonance imaging);
- MRA (magnetic resonance angiogram); or
- EEG (electroencephalogram).

The following benefits are the maximum benefits payable regardless of the number of units purchased:

Air Ambulance. We will pay $500 if a licensed professional air ambulance company transports any Insured Person by air to or from a Hospital or between medical facilities, where treatment for Injuries is provided as the result of a Covered Accident. The air ambulance transportation must occur within 48 hours after the Covered Accident. This amount will be paid once per Covered Accident.

Ambulance. We will pay $100 if a licensed professional ambulance company transports any Insured Person by ground transportation to or from a Hospital or between medical facilities, where treatment for Injuries is provided for Injuries resulting from a Covered Accident. The ambulance transportation must occur within 90 days from the Covered Accident. This amount will be paid once per Covered Accident.

Appliance. We will pay $100 if any Insured Person is injured as the result of a Covered Accident and a Physician prescribes the use of a medical appliance as an aid in personal locomotion or mobility. Crutches, braces, walkers and wheelchairs are examples of medical appliances. The use of an appliance must be prescribed within 90 days after the Covered Accident. This amount will be paid once per Covered Accident.

Blood/Plasma/Platelets. We will pay $300 if the primary Insured Person ($200 if the Spouse/Dependent Child) is injured as the result of a Covered Accident and requires the transfusion, administration, cross-matching, typing and processing of blood, blood plasma or platelets as the result of the injury. The blood, blood plasma or platelets must be administered within 90 days after the Covered Accident. This amount will be paid once per Covered Accident.

Emergency Room Treatment. We will pay $200 if any Insured Person is injured as the result of a Covered Accident and the Insured Person requires examination and treatment by a Physician in an Emergency Room within 72 hours after the Covered Accident. This amount will be paid once per Covered Accident.

Eye Injury. We will pay $200 if any Insured Person receives an eye Injury as the result of a Covered Accident. The eye Injury must require surgery or the removal of a foreign object by a Physician within 90 days after the Covered Accident. This amount will be paid once per Covered Accident. An examination with anesthesia will not be considered surgery.

Gunshot Wound. We will pay $500 if the primary Insured Person is injured by one or more gunshot wounds and did not intentionally shoot themselves. The wound(s) must be caused by a shot from a conventional firearm. A conventional firearm is a weapon which fires a shot (bullet) by gun powder or compressed gas. The wound(s) must require treatment by a Physician, including Confinement within 24 hours and surgery within 72 hours after the injury.

Lodging. We will pay $100 per night for one motel/hotel room, for up to 30 days per Covered Accident, if a companion accompanies the Insured Person. This benefit is payable only for motel/hotel stays during the period of time the Insured Person is Confined to the Hospital. In order for this benefit to be payable, the Hospital in which the Insured Person is Confined must be located more than 100 miles from the residence of the Insured Person.

Physician's Office/Urgent Care. We will pay $50 if any Insured Person receives treatment and/or advice by a Physician in their office or an Urgent Care Facility for Injuries as the result of a Covered Accident. The treatment must occur within 60 days after the Covered Accident and the services provided must be the result of a Covered Accident and not for routine examinations or preventative testing. This amount will be paid once per Covered Accident.

Prosthetic Device/Artificial Limb. We will pay the applicable amount listed below for a prosthetic device/artificial limb which is prescribed by a Physician for functional use when the Insured Person loses a hand, foot or sight of an eye due

to a Covered Accident. The prosthetic device/artificial limb must be received within one year of the Covered Accident. This amount will be paid once per Covered Accident.

One prosthetic device or artificial limb	$500
More than one prosthetic device or artificial limb	$1,000

This benefit will not be paid for:

- hearing aids;
- dental aids, including false teeth;
- eye glasses;
- cosmetic prosthesis such as wigs; or
- joint replacement such as an artificial hip or knee.

Ruptured Disc. We will pay $400 for any and all ruptured discs in the spine suffered by an Insured Person as the result of a Covered Accident. For this benefit to be paid, all of the following must occur.

- the ruptured disc(s) must be treated by a Physician within 60 days after the Covered Accident; and
- the ruptured disc(s) must be repaired through surgery by a Physician within one year after the Covered Accident.

This amount will be paid once per Covered Accident.

Surgery. We will pay $1,000 if any Insured Person undergoes open abdominal or thoracic surgery, within 72 hours after the Covered Accident, to repair internal Injuries received as a result of the Covered Accident. For open abdominal or thoracic exploratory surgery without repair, We will pay a benefit of $100. For exploratory or other surgery without repair, We will pay a benefit of $100. This amount will be paid once per Covered Accident. Hernia repair will not be covered.

Tendon/Ligament/Rotator Cuff. We will pay $500 for the surgical repair of any and all torn, ruptured or severed tendons, ligaments or rotator cuff which an Insured Person suffered as the result of a Covered Accident. The surgery must be performed by a Physician within 90 days after the Covered Accident.

If exploratory arthroscopic surgery is performed and no repair is done, We will pay a benefit of $100.

If any Insured Person receives a fracture or a dislocation and tears, ruptures or severs a tendon/ligament/rotator cuff in the same Covered Accident, only one benefit will be paid. We will pay the larger of the Tendon/Ligament/Rotator Cuff Benefit, the Fracture Benefit or the Dislocation Benefit.

Transportation. We will pay $300 per round trip if any Insured Person must travel more than 100 miles round trip from their residence to receive treatment and be confined in a Hospital for Injuries received as the result of a Covered Accident. Treatment must be prescribed by a Physician and not available locally. This benefit is payable for up to three round trips per Covered Accident. This benefit is not payable for transportation by ambulance or air ambulance.

EXCLUSIONS

We will not pay benefits for losses that are caused by or are the result of any Insured Person(s):

1) operating, learning to operate, or serving as a crew member of any aircraft;
2) engaging in hang-gliding, hot air ballooning, bungee jumping, parachuting, scuba diving, sail gliding, parasailing, parakiting or any similar activities;
3) riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
4) officiating, coaching, practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received;
5) who has any sickness or condition caused by a sickness independent of the Covered Accident, including physical or mental infirmity. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by any injury;
6) being exposed to war or any act of war, declared or undeclared;
7) actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;
8) suffering from Mental or Nervous Disorders;
9) being addicted to drugs or suffering from alcoholism;
10) being under the influence of an excitant, depressant, hallucinogen, narcotic, or any other drug or intoxicant, including those prescribed by a Physician that are misused;
11) receiving Injuries caused directly or indirectly while under the influence of a controlled substance or by intoxication as defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred;
12) having cosmetic surgery or other elective procedures that are not medically necessary;

13) having dental treatment except as the result of an Injury;
14) having a hernia;
15) participating in or attempting to commit a felony;
16) being incarcerated in a penal institution or government detention facility;
17) driving any taxi for wage, compensation or profit;
18) engaging in an illegal activity or occupation;
19) self-inflicting an Injury intentionally; or
20) committing or attempting to commit suicide, while sane or insane;

TERMINATION

Coverage will terminate and no Benefits will be payable under this Policy and the attached Riders, if any, on the earliest of the following:

- when any premium due for this Policy is not paid before the end of the Grace Period;
- when You give Us a written request to do so;
- when You establish residence in a foreign country;
- upon Your death;
- attainment of age 70

Coverage of a Dependent Child will terminate when this policy terminates, or when any such child no longer meets the definition of Dependent Child.

Coverage of a Spouse will terminate on the earliest of the following:

- when this policy terminates;
- upon Spouse's death;
- upon Spouse's attainment of age 70; or
- on the next premium due date after the date of divorce or legal separation from You, the named Insured.

It is Your responsibility to notify Us of an Insured's loss of eligibility of coverage. Our acceptance of premium for such person whose coverage has terminated will not extend coverage for such persons. Our only liability will be to return the premium for the period the person is not covered.

CLAIM PROVISIONS

Notice of Claim: You should give Us notice that You have a claim in writing. Unless it's not possible, You should give Us notice within 20 days after You suffer a loss. Your notice should include Your name and Policy Number. Notice can be given to The Company at Our office.

Claim Forms: Once You give Us Notice of Claim, We will send claim forms. If We do not send these within 15 days of Notice of Claim, Your written statement will be accepted. The written statement must state the cause, nature, and extent of Your loss, and be given in the Proof of Loss time limit.

Proof of Loss: Proof of Loss ("Proof") is due within 120 days after the date you suffer a loss. If You cannot meet this deadline, You must submit Proof as soon as possible. We will not reduce or deny Benefits because Proof is late. However, You must give Us Proof within 12 months unless You lack legal capacity.

Time of Payment of Claims: When We receive Your Proof of Loss, We will pay the Benefits then due, except as otherwise stated in any benefit provision.

Payment of Claims: We pay Benefits to You. If You die, unpaid Benefits go to Your Beneficiary or Beneficiaries. If You have not named a Beneficiary, Benefits will be paid to Your estate. We can pay up to $1,000 to a relative instead of Your estate. We can also do this if You lack legal capacity.

GENERAL PROVISIONS

Entire Policy: The contract between You and Central United includes this Policy, Your Policy, application and any Riders or Endorsements attached to this Policy by Us. Your Policy is issued in return for Your application and the first premium.

Only Central United's President or any of Our Vice Presidents, Secretaries, or Assistant Secretaries can change or waive the terms of Our contract. No sales agent or any other person can do so. Any changes must be in writing and signed by one of these officers.

Statements Made In Your Application: After Your Policy has been in force for 2 years after the Issue Date, We cannot use Your application answers against You unless they are fraudulent. No claim for loss that starts after 2 years from the Issue Date will be reduced or denied because a physical condition existed before the Issue Date unless it is limited or was excluded by name or specific description.

Misstatement of Age: If Your Age was misstated in the application, the Policy Benefits will be changed to those the premium paid would have provided for the correct Age.

Physical Examination: We have the right to have You examined by Physicians when reasonably necessary. A claim must be pending. The exam is at Our expense.

Conformity With State Statutes: The law of Your state of residence applies. If this Policy conflicts with Your state's laws on the Issue Date, it is considered changed to meet those laws. The change will be to the law's minimum requirement.

Legal Actions: No legal action can be brought before 60 days or after 3 years after Proof of Loss is given.

Term of Coverage: The initial term of this Policy begins on the Issue Date shown in the Policy Schedule at 12:01 am, Standard Time of the place where You then reside and ends at 12:01 am, Standard Time of the place where You then reside on the date specified in the Termination provision.

CENTRAL UNITED LIFE INSURANCE COMPANY
[10700 Northwest Freeway
Houston, Texas 77092]
Customer Service: [800-669-9030]

24-HOUR ACCIDENT EXPENSE POLICY
Guaranteed Renewable to age 70
Company may change Table of Premium Rates

READ YOUR POLICY CAREFULLY

CENTRAL UNITED LIFE INSURANCE COMPANY

A Stock Company

[10700 Northwest Freeway
Houston, Texas 77092]
Customer Service: [800-669-9030]

This is a legal contract between the owner of the Policy (You) and Central United Life Insurance Company (Central United). It is issued in return for Your application and first premium. Central United agrees to pay this Policy's Benefits to You if an Insured Person suffers a loss covered under this Policy due to a Covered Accident while this Policy is in effect and the Policy's provisions are met.

RENEWAL PROVISION

You have the right to renew this Policy until age 70 if You pay the correct premium when due or within the Grace Period. If premiums are paid on time, We cannot (prior to age 70) cancel this Policy or place any restrictive rider on it. We reserve the right to change premiums from time to time. If We do change premiums, We will only do so only if: 1) We change the premiums for all policies of this class in Your state; 2) such change is in accordance with the laws and regulations of your state; and 3) We give You 30 days written notice (or longer if required by the state in which this policy is issued) before such change becomes effective.

TEN-DAY FREE LOOK

You may cancel this Policy within 10 days of receiving it. Return the Policy to Central United's Administrative Office or to Your Central United sales agent. As soon as You deliver or mail the Policy to Us, it is treated as if it was never issued. We will refund Your premium payment when We receive the Policy back.

CANCELLATION

After the 10-day free look period, You may cancel this Policy by notifying Us in writing that You wish to do so. Cancellation of Your Policy will be effective on the date We receive Your written notice unless Your notice specifies a later date. We will promptly refund any premium paid for coverage after the cancellation date. Cancellation of this Policy will be without prejudice to any claim made prior to the termination of the contract.

Central United Life Insurance Company has signed this Policy on the Issue Date.

[Mary Lou Rainey
Secretary]

[Dan George
President]

ACCIDENT EXPENSE POLICY

Limited Benefits for Accident While Off-the-Job.
This is an accident only policy which does not pay benefits for a loss from sickness.
It does not pay benefits for loss from injuries received while working for wage or profit.
Guaranteed Renewable to age 70
Company may change Table of Premium Rates

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CENTRAL UNITED LIFE INSURANCE COMPANY

[10700 Northwest Freeway
Houston, Texas 77092]

POLICY SCHEDULE

ACCIDENT EXPENSE POLICY

Primary Insured: [John Q. Doe]
Policy Number: [12 345678]
Effective Date: [02/01/2011]
Insured Dependents:
Spouse: [Jane Doe]
[ ]
[ ]
[ ]
[ ]

Issue Age: [52]

Initial Premium $[33.00]
Mode of Payment [Monthly]

FORM #	BENEFIT DESCRIPTION		PREMIUM
[HPACC2010-NOC]	Guaranteed Renewable to age 70, subject to the Company's Right to Change Premium		
	Accidental Death Benefit Insured		$[23.00]
	Primary Insured	$[25,000, 50,000]	
	Spouse	$[10,000, 20,000]	
	Child(ren)	$[5,000, 10,000]	
	Accidental Death – Common Carrier		Accidental Death Benefit will be doubled.
[HRWEL2010]	[Wellness Rider	$60.00]	$[10.00]

DEFINITIONS

AGE: Your Age as of your last birthday.

AMBULANCE: A ground or air vehicle which is licensed as required by law, as an Ambulance, and is equipped to transport sick or injured persons.

CONFINED/CONFINEMENT: An Insured Person's Medically Necessary admission to and subsequent continued stay in a Hospital as an overnight bed patient for which a charge is made for room and board.

COVERED ACCIDENT: An accidental bodily injury that happens to an Insured Person while this Policy is in force and occurs while the Insured Person is Off-the-Job.

DENTAL TREATMENT: Treatment of the teeth and/or periodontal area.

DEPENDENT CHILD(REN): Any natural child, step-child, legally adopted child or child placed into Your custody for adoption who is: (a) unmarried; (b) living with You in a regular parent – child relationship; (c) qualified as a dependent of You or Your Spouse for tax purposes according to the United States Internal Revenue Code; and (d) younger than age 26.

EMERGENCY CARE: Those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her injury is of such a nature that failure to obtain immediate medical care could result in:

- placing the patient's health in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

HOSPITAL: An institution operated pursuant to law for the care and treatment of injured and sick persons which:

- maintains (either on its premises, or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians) organized facilities for medical, diagnostic and surgical care for injured and sick persons on an inpatient basis for which a charge is made that the Insured Person is legally obligated to pay;
- maintains a staff of one or more duly licensed Physicians;
- provides 24 hour nursing care by or under the supervision of an R.N.;
- maintains and operates a minimum of 5 beds; and
- maintains permanent medical history records.

Hospital does not include any facility which is used principally as a facility for the aged, drug addicts, alcoholics, custodial care, educational care, rest or convalescence, or care of Mental or Nervous Disorders.

INSURED PERSON: You (primary insured) and Your Spouse and Dependent Child(ren) as listed on the application, and named in the Policy Schedule.

INTENSIVE CARE UNIT: Intensive Care Units are defined as an area or unit of a hospital that is separate and apart from the surgical recovery room and from the general service rooms, beds and wards. It must have 24-hour nursing care attended by nurses assigned on a full-time basis exclusive to such unit; and a stay in the unit must be at the direction and/or supervision of a full-time Physician director or a standing "intensive care" committee of the medical staff. Intensive Care Units include an intensive cardiac care unit and a neo-natal intensive care unit. It does not include: progressive care units; sub-acute intensive care units; intermediate care units; private monitored rooms; observation units; or other lesser treatment units.

ISSUE DATE: The effective date of coverage provided by this Policy. See the Policy Schedule.

MEDICALLY NECESSARY OR MEDICAL NECESSITY: The necessity of a service or supply as appropriate for the diagnosis or treatment of a Covered Accident based on generally accepted current medical practice. A service or supply will not be considered Medically Necessary if:

- it is provided only as a convenience to the Insured Person or provider;
- it is not appropriate treatment for the Insured Person's diagnosis or symptoms; or
- it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

MENTAL OR NERVOUS DISORDER: Any disorder classified as such in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

OFF-THE-JOB: While You are not working at any job for a wage or profit.

PHYSICIAN: A licensed medical provider who acts within the scope of his or her license and provides treatment or care necessary for a Covered Accident. The Physician must be someone other than You or a member of Your immediate family.

POLICY: This Accident Expense contract.

POLICY SCHEDULE: Page 3 of this Policy.

RENEWAL PREMIUMS: The amount You must pay Us to keep this Policy in force.

SPOUSE: Your spouse for whom You have applied for insurance coverage under this Policy and for whom premium payments are made. At the time of application, Your spouse must be at least 18 years of age and no more than 69 years of age.

WE, OUR, US, THE COMPANY: Central United Life Insurance Company (Central United).

YOU, YOUR: The Insured/Owner of this Policy. If the Insured is not the Owner, You refers to either as the context allows.

PREMIUMS AND REINSTATEMENT

Premium Payments: The first premium is due on the Issue Date. Premiums will include rider premiums, if any. premiums paid after the first premium are Renewal Premiums. We may change Renewal Premiums. The rules for doing this are on Page 1.

The date Renewal Premiums are due is called the due date. Subject to the Grace Period, Your Policy will end if a Renewal Premium is not paid by the due date. All premiums are payable to Us.

Grace Period: You have a 31-day Grace Period to pay Renewal Premiums. The Grace Period starts on the due date and ends 31 days later. During the Grace Period, Your Policy stays in force. If You do not pay the Renewal Premium by the end of the Grace Period, Your Policy will lapse (end).

Reinstatement: Our acceptance of premium for this policy beyond the grace period will not reinstate the policy. Our only liability will be to return the premium. In order to reinstate the policy, all insureds requesting coverage must complete an application for reinstatement subject to our underwriting guidelines. The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement. In all other respects the Insured and Company shall have the same rights thereunder as they had under this Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement

Refund of Unearned Premium: Within 30 days of proof of an Insured Person's death, We will refund any unearned premium paid for such person for any period beyond the end of the month in which death occurred.

Unpaid Premiums: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

BENEFITS

Benefits will not be paid for injuries received while working for a wage or profit. This policy will pay the following benefits for loss resulting from a Covered Accident for each unit purchased:

Accidental Death Benefit. We will pay the benefit amount shown on the Policy Schedule if any Insured Person is injured as the direct result of a Covered Accident. The injury must be the cause of the Insured Person's death and occur within 90 days after the Covered Accident.

Accidental Death – Common Carrier. We will pay the benefit amount shown on the Policy Schedule if any Insured Person is injured as the result of a Covered Accident while a fare-paying passenger on a common carrier operating on a regularly scheduled basis such as a plane, bus or train. The injury must be the cause of the Insured Person's death and occur within 90 days after the Covered Accident. If We pay this benefit, the Accidental Death Benefit will not be paid.

Burn. We will pay the applicable amount listed below if any Insured Person receives burns as the result of a Covered Accident which are treated by a Physician within 72 hours after the Covered Accident. We will pay only one benefit amount per Covered Accident.

We will pay 25% of the applicable Burn Benefit if any Insured Person receives a skin graft for a burn for which a benefit was paid under the Burn Benefit of this policy. This benefit will be payable only once per Covered Accident.

	You	**Spouse/Child**
Second degree burns which cover at least 36% of the body surface	$ 375	$ 150
Third degree burns which cover at least 1% of the body surface but less than 20% of the body surface	$ 750	$ 300
Third degree burns which cover 20% or more of the body surface	$5,000	$2,000

Dislocated (separated) Joint. We will pay the applicable amount listed below if any Insured Person receives a dislocation as the result of a Covered Accident. As this list is not complete, We will pay a benefit similar to the dislocation suffered if not listed. A dislocation is a completely separated joint. In order for this benefit to be payable for the joint involved, all of the following must occur:

- it must be diagnosed as a dislocation by a Physician within 90 days after the Covered Accident;
- the dislocation must require correction with anesthesia by a Physician; and
- the dislocation will be corrected by open (surgical) or closed (non-surgical) reduction.

If any Insured Person receives more than one dislocation in a Covered Accident and requires open or closed reduction, We will pay for all dislocations. However, We will pay no more than two times the amount for the joint involved which has the highest benefit amount.

If the dislocation requires reduction without anesthesia by a Physician, We will pay 25% of the amount listed for a closed reduction of the joint involved.

If a Physician diagnoses the dislocation as an incomplete dislocation, We will pay 25% of the amount listed for a closed reduction of the joint involved. An incomplete dislocation is a dislocation in which the joint is not completely separated.

We will pay this benefit only for the first dislocation of a joint after the policy Issue Date. Subsequent dislocations of the same joint after the policy Issue Date will not be covered.

Joint	**Closed Reduction**	**Open Reduction**
Hip	$1,000	$2,000
Knee (except Patella)	500	1,000
Ankle	400	800
Bone or bones of the foot (other than toes)	400	800
Collarbone (Sternoclavicular)	250	500
Lower Jaw	150	300
Shoulder (Glenohumeral)	150	300
Elbow	150	300
Wrist	150	300
Bone or bones of the hand (other than fingers)	150	300
Collarbone (Acromioclavicular and separation)	50	100
One toe or finger	50	100

Emergency Dental Work. We will pay the applicable amount listed below for dental work required by an Insured Person as the result of Injuries received in a Covered Accident.

Any and all broken teeth repaired with crown(s)	$150
Any and all broken teeth resulting in extraction(s)	$ 50

Benefits are payable only once per Covered Accident, regardless of the number of teeth involved.

Fracture (broken bone). We will pay the applicable amount listed below if any Insured Person receives a fracture as the result of a Covered Accident. As this list is not complete, We will pay a benefit similar to the fracture suffered if not listed.

A fracture is a break in a bone which can be seen by X-ray. In order for this benefit to be payable for the bone involved, all of the following must occur:

- it must be diagnosed as a fracture by a Physician within 90 days after the Covered Accident; and
- the fracture must require open (surgical) or closed (non-surgical) reduction by a Physician.

The maximum benefit payable for all fractures as the result of a Covered Accident is equal to two times the amount of the fracture with the highest benefit amount.

If a Physician diagnoses the fracture as a chip fracture, We will pay 25% of the amount listed for the closed reduction for the bone involved. A chip fracture is a fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

Bone	**Closed Reduction**	**Open Reduction**
Skull (except bones of face or nose)		
Depressed skull fracture	$1,250	$2,500
Simple non-depressed skull fracture	500	1,000
Hip, thigh (Femur)	750	1,500
Vertebrae, body of (excluding Vertebral Processes)	400	800
Pelvis (includes Ilium, Ischium, Pubis, Acetabulum except Coccyx)	400	800
Leg (Tibia and/or Fibula)	400	800
Bones of face or nose (except Mandible or Maxilla)	175	350
Upper jaw, Maxilla (except Alveolar Process)	175	350
Upper arm between elbow and shoulder (Humerus)	175	350
Lower jaw, Mandible (except Alveolar Process)	150	300
Shoulder blade (Scapula), collar bone (Clavicle, Sternum)	150	300
Vertebral Processes	150	300
Forearm (radius and/or Ulna)	150	300
Knee cap (Patella)	150	300
Hand, foot (except fingers, toes)	150	300
Ankle, wrist	150	300
Rib	125	250
Coccyx	100	200
Finger, toe	25	50

Hospital Admission. We will pay $500 if any Insured Person is Confined to a Hospital as the result of Injuries received in a Covered Accident. The Insured Person must be Confined within 180 days after the Covered Accident. This benefit will not be paid for:

- Emergency Room treatment;
- outpatient treatment; or
- a stay of less than 20 hours.

This amount will be paid once per Covered Accident.

Hospital Confinement. We will pay $100 per day for up to 90 days per Covered Accident if any Insured Person is Confined in a Hospital or Hospital Sub-Acute Intensive Care Unit as the result of Injuries received in a Covered Accident. The Insured Person must become Confined in a Hospital or a Hospital Sub-Acute Intensive Care Unit within 180 days after the Covered Accident. We will pay benefits for only one Hospital Confinement at a time even if it is caused by more than one Covered Accident. We will not pay this benefit for:

- Emergency Room treatment;
- outpatient treatment; or
- a stay of less than 20 hours.

Hospital Intensive Care Unit Confinement. We will pay $200 per day for up to 15 days per Covered Accident if any Insured Person is Confined to a Hospital Intensive Care Unit as the result of Injuries received in a Covered Accident. The Confinement in a Hospital Intensive Care Unit must begin within 30 days after the Covered Accident.

If any Insured Person is Confined to a Hospital Intensive Care Unit that does not meet the definition in this policy of a Hospital Intensive Care Unit, We will pay the Hospital Confinement Benefit. The Hospital Intensive Care Unit Confinement Benefit and the Hospital Confinement Benefit will not be paid concurrently. If any Insured Person is Confined in a Hospital Intensive Care Unit for more than 15 days, the Hospital Confinement Benefit will begin on the 16th day. The total amount payable per Covered Accident will not exceed 90 days for Hospital Confinement and 15 days for Hospital Intensive Care Unit Confinement.

Knee Cartilage – Torn. We will pay $500, reduced by any benefit paid for arthroscopic surgery previously performed, if any Insured Person receives a torn knee cartilage (meniscus) as the result of a Covered Accident. For this benefit to be paid, all of the following must occur:
- it must be treated by a Physician within 60 days after the Covered Accident; and
- it must be repaired through surgery by a Physician within 180 days after the Covered Accident.

If exploratory arthroscopic surgery is performed within 180 days of the Covered Accident and no repair is done, or if the cartilage is shaved (debridement), We will pay $100.

Laceration. We will pay the applicable amount listed below if any Insured Person receives a laceration as the result of a Covered Accident. The laceration must be repaired by a Physician within 72 hours after the Covered Accident. The amount We will pay is based on the total length of all lacerations received in any one Covered Accident which require repair. If the laceration is severe enough to require stitches but the Physician chooses to repair it in another way, We will pay it as a laceration repaired with stitches.

Total of all lacerations is not more than three inches (7.6 cm) long and repaired by stitches, staples or glue	$50
Total of all lacerations is greater than three and not more than five inches (7.6 cm to 12.5 cm) long and repaired by stitches, staples or glue	$200
Total of all lacerations is more than five inches (12.5 cm) long and repaired by stitches, staples or glue	$400

If any Insured Person receives a laceration on a finger, toe, hand, foot or eye and later loses that finger, toe, hand, foot or eye as the result of the same Covered Accident, We will subtract the amount We paid under the Laceration Benefit from the Loss of Finger, Toe, Hand, Foot or Sight of an Eye Benefit.

Loss of Finger, Toe, Hand, Foot or Sight of an Eye. We will pay the applicable amount listed below for loss received as the result of a Covered Accident and in which loss occurs within 90 days after the Covered Accident.

	You	**Spouse/Child**
Loss of both hands, or both feet, or the sight of both eyes, or any combination of two or more listed above	$15,000	$10,000
Loss of one hand, or one foot, or sight of one eye	$7,500	$5,000
Loss of two or more fingers, or two or more toes, or any combination of two or more listed above	$1,500	$1,000
Loss of one finger or one toe	$750	$500

“Loss of a hand” means that the hand is cut off through or above the wrist joint or the use of the hand is medically determined to be permanently lost. “Loss of a foot” means that the foot is cut off through or above the ankle joint or the use of the foot is medically determined to be permanently lost. “Loss of a finger” means that the finger is cut off at the joint proximate to the first interphalangeal joint where it is attached to the hand. “Loss of a toe” means that the toe is cut off at the joint proximate to the first interphalangeal joint where it is attached to the foot. “Loss of sight of an eye” means that at least 80% of vision is permanently lost.

If the Insured Person loses a finger or toe and later loses a hand or foot within 90 days on the same side of the body as the result of the same Covered Accident, We will subtract the amount paid for the loss of a finger or toe from the Loss of Finger, Toe, Hand, Foot or Sight of an Eye Benefit.

Only the highest single benefit will be payable per Covered Accident. Benefits will be paid only once per Covered Accident. If death and Loss of Finger, Toe, Hand, Foot or Sight of an Eye result from the same Covered Accident, only the Accidental Death Benefit will be paid.

Major Diagnostic Exams. We will pay $100 per Calendar Year if an Insured Person requires one of the following exams for Injuries received as the result of a Covered Accident:

- angiogram;
- CT (computerized tomography) scan;
- CTA (computerized tomography angiogram) scan;
- MRI (magnetic resonance imaging);
- MRA (magnetic resonance angiogram); or
- EEG (electroencephalogram).

The following benefits are the maximum benefits payable regardless of the number of units purchased.

Air Ambulance. We will pay $500 if a licensed professional air ambulance company transports any Insured Person by air to or from a Hospital or between medical facilities, where treatment for Injuries is provided as the result of a Covered Accident. The air ambulance transportation must occur within 48 hours after the Covered Accident. This amount will be paid once per Covered Accident.

Ambulance. We will pay $100 if a licensed professional ambulance company transports any Insured Person by ground transportation to or from a Hospital or between medical facilities, where treatment for Injuries is provided for Injuries resulting from a Covered Accident. The ambulance transportation must occur within 90 days from the Covered Accident. This amount will be paid once per Covered Accident.

Appliance. We will pay $100 if any Insured Person is injured as the result of a Covered Accident and a Physician prescribes the use of a medical appliance as an aid in personal locomotion or mobility. Crutches, braces, walkers and wheelchairs are examples of medical appliances. The use of an appliance must be prescribed within 90 days after the Covered Accident. This amount will be paid once per Covered Accident.

Blood/Plasma/Platelets. We will pay $300 if the primary Insured Person ($200 if the Spouse/Dependent Child) is injured as the result of a Covered Accident and requires the transfusion, administration, cross-matching, typing and processing of blood, blood plasma or platelets as the result of the injury. The blood, blood plasma or platelets must be administered within 90 days after the Covered Accident. This amount will be paid once per Covered Accident.

Emergency Room Treatment. We will pay $200 if any Insured Person is injured as the result of a Covered Accident and the Insured Person requires examination and treatment by a Physician in an Emergency Room within 72 hours after the Covered Accident. This amount will be paid once per Covered Accident.

Eye Injury. We will pay $200 if any Insured Person receives an eye Injury as the result of a Covered Accident. The eye Injury must require surgery or the removal of a foreign object by a Physician within 90 days after the Covered Accident. This amount will be paid once per Covered Accident. An examination with anesthesia will not be considered surgery.

Gunshot Wound. We will pay $500 if the primary Insured Person is injured by one or more gunshot wounds and did not intentionally shoot themselves. The wound(s) must be caused by a shot from a conventional firearm. A conventional firearm is a weapon which fires a shot (bullet) by gun powder or compressed gas. The wound(s) must require treatment by a Physician, including Confinement within 24 hours and surgery within 72 hours after the injury.

Lodging. We will pay $100 per night for one motel/hotel room, for up to 30 days per Covered Accident, if a companion accompanies the Insured Person. This benefit is payable only for motel/hotel stays during the period of time the Insured Person is Confined to the Hospital. In order for this benefit to be payable, the Hospital in which the Insured Person is Confined must be located more than 100 miles from the residence of the Insured Person.

Physician's Office/Urgent Care. We will pay $50 if any Insured Person receives treatment and/or advice by a Physician in their office or an Urgent Care Facility for Injuries as the result of a Covered Accident. The treatment must occur within 60 days after the Covered Accident and the services provided must be the result of a Covered Accident and not for routine examinations or preventative testing. This amount will be paid once per Covered Accident.

Prosthetic Device/Artificial Limb. We will pay the applicable amount listed below for a prosthetic device/artificial limb which is prescribed by a Physician for functional use when the Insured Person loses a hand, foot or sight of an eye due to a Covered Accident. The prosthetic device/artificial limb must be received within one year of the Covered Accident. This amount will be paid once per Covered Accident.

One prosthetic device or artificial limb	$500
More than one prosthetic device or artificial limb	$1,000

This benefit will not be paid for:

- hearing aids;
- dental aids, including false teeth;
- eye glasses;
- cosmetic prosthesis such as wigs; or
- joint replacement such as an artificial hip or knee.

Ruptured Disc. We will pay $400 for any and all ruptured discs in the spine suffered by an Insured Person as the result of a Covered Accident. For this benefit to be paid, all of the following must occur.

- the ruptured disc(s) must be treated by a Physician within 60 days after the Covered Accident; and
- the ruptured disc(s) must be repaired through surgery by a Physician within one year after the Covered Accident.

This amount will be paid once per Covered Accident.

Surgery. We will pay $1,000 if any Insured Person undergoes open abdominal or thoracic surgery, within 72 hours after the Covered Accident, to repair internal Injuries received as a result of the Covered Accident. For open abdominal or thoracic exploratory surgery without repair, We will pay a benefit of $100. For exploratory or other surgery without repair, We will pay a benefit of $100. This amount will be paid once per Covered Accident. Hernia repair will not be covered.

Tendon/Ligament/Rotator Cuff. We will pay $500 for the surgical repair of any and all torn, ruptured or severed tendons, ligaments or rotator cuff which an Insured Person suffered as the result of a Covered Accident. The surgery must be performed by a Physician within 90 days after the Covered Accident.

If exploratory arthroscopic surgery is performed and no repair is done, We will pay a benefit of $100.

If any Insured Person receives a fracture or a dislocation and tears, ruptures or severs a tendon/ligament/rotator cuff in the same Covered Accident, only one benefit will be paid. We will pay the larger of the Tendon/Ligament/Rotator Cuff Benefit, the Fracture Benefit or the Dislocation Benefit.

Transportation. We will pay $300 per round trip if any Insured Person must travel more than 100 miles round trip from their residence to receive treatment and be confined in a Hospital for Injuries received as the result of a Covered Accident. Treatment must be prescribed by a Physician and not available locally. This benefit is payable for up to three round trips per Covered Accident. This benefit is not payable for transportation by ambulance or air ambulance.

EXCLUSIONS

We will not pay benefits for losses that are caused by or are the result of any Insured Person(s):

1) operating, learning to operate, or serving as a crew member of any aircraft;
2) engaging in hang-gliding, hot air ballooning, bungee jumping, parachuting, scuba diving, sail gliding, parasailing, parakiting or any similar activities;
3) riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
4) officiating, coaching, practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received;
5) who has any sickness or condition caused by a sickness independent of the Covered Accident, including physical or mental infirmity. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by any injury;
6) being exposed to war or any act of war, declared or undeclared;
7) actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;
8) suffering from Mental or Nervous Disorders;
9) being addicted to drugs or suffering from alcoholism;
10) being under the influence of an excitant, depressant, hallucinogen, narcotic, or any other drug or intoxicant, including those prescribed by a Physician that are misused;

11) receiving Injuries caused directly or indirectly while under the influence of a controlled substance or by intoxication as defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred;
12) having cosmetic surgery or other elective procedures that are not medically necessary;
13) having dental treatment except as the result of an Injury;
14) having a hernia;
15) participating in or attempting to commit a felony;
16) being incarcerated in a penal institution or government detention facility;
17) driving any taxi for wage, compensation or profit;
18) engaging in an illegal activity or occupation;
19) self-inflicting an Injury intentionally; or
20) committing or attempting to commit suicide, while sane or insane;

TERMINATION

Coverage will terminate and no Benefits will be payable under this Policy and the attached Riders, if any, on the earliest of the following:

- when any premium due for this Policy is not paid before the end of the Grace Period;
- when You give Us a written request to do so;
- when You establish residence in a foreign country;
- upon Your death; or
- primary insured's attainment of age 70.

Coverage of a Dependent Child will terminate when this policy terminates, or when any such child no longer meets the definition of Dependent Child.

Coverage of a Spouse will terminate on the earliest of the following:

- when this policy terminates;
- upon Spouse's death;
- upon Spouse's attainment of age 70; or
- on the next premium due date after the date of divorce or legal separation from You, the named Insured.

It is Your responsibility to notify Us of an Insured's loss of eligibility of coverage. Our acceptance of premium for such person whose coverage has terminated will not extend coverage for such persons. Our only liability will be to return the premium for the period the person is not covered.

CLAIM PROVISIONS

Notice of Claim: You should give Us notice that You have a claim in writing. Unless it's not possible, You should give Us notice within 20 days after You suffer a loss. Your notice should include Your name and Policy Number. Notice can be given to The Company at Our office.

Claim Forms: Once You give Us Notice of Claim, We will send claim forms. If We do not send these within 15 days of Notice of Claim, Your written statement will be accepted. The written statement must state the cause, nature, and extent of Your loss, and be given in the Proof of Loss time limit.

Proof of Loss: Proof of Loss ("Proof") is due within 120 days after the date you suffer a loss. If You cannot meet this deadline, You must submit Proof as soon as possible. We will not reduce or deny Benefits because Proof is late. However, You must give Us Proof within 12 months unless You lack legal capacity.

Time of Payment of Claims: When We receive Your Proof of Loss, We will pay the Benefits then due, except as otherwise stated in any benefit provision.

Payment of Claims: We pay Benefits to You. If You die, unpaid Benefits go to Your Beneficiary or Beneficiaries. If You have not named a Beneficiary, Benefits will be paid to Your estate. We can pay up to $1,000 to a relative instead of Your estate. We can also do this if You lack legal capacity.

GENERAL PROVISIONS

Entire Policy: The contract between You and Central United includes this Policy, Your Policy, application and any Riders or Endorsements attached to this Policy by Us. Your Policy is issued in return for Your application and the first premium.

Only Central United's President or any of Our Vice Presidents, Secretaries, or Assistant Secretaries can change or waive the terms of Our contract. No sales agent or any other person can do so. Any changes must be in writing and signed by one of these officers.

Statements Made In Your Application: After Your Policy has been in force for 2 years after the Issue Date, We cannot use Your application answers against You unless they are fraudulent. No claim for loss that starts after 2 years from the Issue Date will be reduced or denied because a physical condition existed before the Issue Date unless it is limited or was excluded by name or specific description.

Misstatement of Age: If Your Age was misstated in the application, the Policy Benefits will be changed to those the premium paid would have provided for the correct Age.

Physical Examination: We have the right to have You examined by Physicians when reasonably necessary. A claim must be pending. The exam is at Our expense.

Conformity With State Statutes: The law of Your state of residence applies. If this Policy conflicts with Your state's laws on the Issue Date, it is considered changed to meet those laws. The change will be to the law's minimum requirement.

Legal Actions: No legal action can be brought before 60 days or after 3 years after Proof of Loss is given.

Term of Coverage: The initial term of this Policy begins on the Issue Date shown in the Policy Schedule at 12:01 am, Standard Time of the place where You then reside and ends at 12:01 am, Standard Time of the place where You then reside on the date specified in the Termination provision.

CENTRAL UNITED LIFE INSURANCE COMPANY

[10700 Northwest Freeway
Houston, Texas 77092]
Customer Service: [800-669-9030]

ACCIDENT EXPENSE POLICY
Limited Benefits for Accident While Off-the-Job.
It does not pay benefits for loss from injuries or sickness received while working for wage or profit.

Guaranteed Renewable to age 70
Company may change Table of Premium Rates

READ YOUR POLICY CAREFULLY

CENTRAL UNITED LIFE INSURANCE COMPANY
A Stock Company

[10700 Northwest Freeway
Houston, Texas 77092]
Customer Service: [800-669-9030]

ANNUAL WELLNESS BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached and is subject to all the provisions, conditions, limitations, and exclusions of such Policy which are not in conflict with this Rider. It is issued in consideration of Your Application and the timely payment of premiums by the Policyholder for this Rider. This Rider takes effect on the Policy Effective Date.

RIDER BENEFIT

We will pay $60 once each Policy year if You, Your Spouse or any one family member (Dependent) named in the Policy Schedule undergo any of the following examinations: an annual physical examination, dental exam, mammogram, Pap smear, eye examination, immunization, flexible sigmoidoscopies, PSA test, ultrasounds or blood screening test. Service must be under the supervision of, or recommended by, a Physician and received while Your Policy is in force. A charge must be incurred. All dependent children will be treated as one insured for this benefit. This policy must be in force for 12 months before this benefit is payable.

TERMINATION

This Rider terminates on the earlier of the following dates:

1. the date the Policy to which this Rider is attached terminates;
2. the end of the Grace Period following the date any required premium for this Rider is not paid by the Policyholder; or
3. when You give Us written notice to terminate this Rider.

Coverage for an insured Spouse or Dependent Child will terminate on the earlier of the following dates:

1. the date Your coverage ends; or
2. the date that coverage for the Spouse or Dependent Child terminates under the Policy to which this Rider is attached.

Signed at Our Home Office in Houston, Texas.

[Mary Lou Rainey
Secretary]

[Dan George
President]

CENTRAL UNITED LIFE INSURANCE COMPANY

10700 Northwest Freeway, Houston, Texas 77092

Application for: ❑ 24-Hour ❑ Off-the-Job Accident Expense Policy

Requested Effective Date: _____

PART 1 - GENERAL INFORMATION

1. PERSONS TO BE COVERED

Name (Please PRINT Full Name)	Relationship	Gender	Date of Birth	Age	Height Ft. In.	Weight Lbs.	Social Security Number
1.	Applicant						- -
2.	Spouse						- -
3.	Child						- -
4.	Child						- -
5.	Child						- -

2. APPLICANT'S HOME ADDRESS

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Email Address: _____

3. PREMIUM PAYOR ADDRESS (if different than Applicant)

Premium Payor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

4. EMPLOYMENT INFORMATION (All adult applicants)

Employer's Name: _____

Occupation/Duties: _____

Spouse's Employer's Name (if applying): _____

Spouse's Occupation/Duties: _____

5. BENEFIT INFORMATION:

Monthly Premium: $ _____

Benefit Amount: ❑ 1.0 Unit ❑ 2.0 Units

Plan Type: ❑ Individual ❑ Individual & Spouse ❑ Single Parent ❑ Family

Billing Method: ❑ Monthly Bank Draft ❑ Direct Bill ❑ List Bill

Billing Mode: ❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

6. OPTIONAL RIDER:

Annual Wellness Benefit Rider Yes ❑ No ❑

Premium: $ _____

7. BENEFICIARY

Name: _____

Relationship: _____

8. PRIMARY PHYSICIAN

Name: _____

Address: _____

Phone: _____

PART 2 - REPRESENTATION & QUESTIONS OF THE APPLICANT

		YES	NO
1.	Are all persons to be insured to the best of your knowledge and belief in good health and free from physical impairment or abnormality?	❑	❑
2a.	Is any person to be insured engaged in any hazardous sports or activities including racing, but not limited to parachuting, rodeo riding, motorcycling, mountain climbing, scuba diving or intend to do so?	❑	❑
2b.	Is any person to be insured a member/participant in a semi-professional or professional sport?	❑	❑
3a.	Have you had a driver's license suspended or revoked within the past 3 years?	❑	❑
3b.	Have you had a DWI or DUI within the past 3 years?	❑	❑
3c.	Is any person to be insured currently under treatment or has any person to be insured been under treatment for drug or alcohol abuse in the past 3 years?	❑	❑
4.	Are all persons to be insured ages 19 to 25 years old enrolled as a full time student in an accredited school or college?	❑	❑
5.	Is there any other health, accident or disability insurance in force on the proposed insured?	❑	❑
6.	Will the insurance applied for replace or change any existing insurance?	❑	❑

If YES, give name of Company and type of insurance: _____

If Bank Draft Authorization, ATTACH VOIDED CHECK HERE and sign authorization at right.

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Central United Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original. Requested Draft Date: _____

_____ X _____

Date — Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ (Name) I hereby authorize _____ (Name of Employer)

to deduct from my salary and pay to Central United Life Insurance Company, Houston, Texas, the monthly deposits as set forth below. Beginning with the month of _____ (Month), 20 _____ $ _____ each month.

_____ (Signature of Employee) _____ (Date)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

A. I hereby authorize and request any physician, hospital, dentist, pharmacy, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Central United Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in the circumstances permitted by state and federal law.

B. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer, or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Central United Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy.

C. Central United Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply.

D. This authorization will be valid from the date signed for a period of twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I understand that revocation of this authorization may result in the application being declined and the policy may not be issued.

E. I authorize Central United Life Insurance Company to obtain an investigative consumer report on me.

Dated: _____ Dated at: _____

Signed X _____ (Signature of Proposed Insured) Signed X _____ (Signature of Spouse)

APPLICANT'S STATEMENT

I hereby apply to Central United Life Insurance Company for a policy to be issued in reliance on my written answers to the foregoing questions. I understand that: (a) the policy of insurance I am now applying for will be issued solely upon the written answers to questions and information asked for in this application; (b) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance; and (d) no change to the policy will be valid until approved by an officer of the Company which must be noted on or attached to the policy. I have read, or had read to me, the completed application and realize policy issuance is based upon statements and answers provided herein and they are complete and true to the best of my knowledge and belief. I acknowledge I have received an Outline of Coverage for the policy applied for.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact or material thereto commits a fraudulent insurance act, which may be a crime as determined by a court of law.

Dated at _____ (City, State & Zip) on _____ (Month & Day) 20 _____ .

Signature of Applicant: _____ Signature of Spouse: _____

AGENT'S STATEMENT

I Certify: 1) That any information recorded by me is true and correct to the best of my knowledge and belief. 2) I have given an outline of coverage for the policy applied for to the Applicant. 3) This ❑ does ❑ does not replace other insurance.

Dated _____ (City, State & Zip) on _____ (Month & Day) 20 _____ .

_____ (Agent Name (Print)) _____ (Agent Signature) _____ (Agent Number)

SERFF Tracking Number:	*CEUL-128329220*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*HPACC2010*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*HPACC2010*		
Project Name/Number:	*HPACC2010/HPACC2010*		

Rate Information

Rate data applies to filing.

Filing Method:	New Rate Filing
Rate Change Type:	%
Overall Percentage of Last Rate Revision:	%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Central United Life Insurance Company	%	%				%	%

SERFF Tracking Number:	*CEUL-128329220*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*HPACC2010*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*HPACC2010*		
Project Name/Number:	*HPACC2010/HPACC2010*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 05/04/2012	24 Hour Rates	HPACC2010-24-2	New		24 HR HPACC 2010 Rate Chart Acc ALL.pdf
Approved-Closed 05/04/2012	Non Occupational Rates	HPACC2010-NOC-2	New		NOC HPACC 2010 Rate Chart Acc ALL.pdf

Form HPACC 2010 Accident Policy Rate Schedule

	Weekly Premium		Bi-Weekly Premium		Semi-Monthly Premium		Monthly Premium	
24-Hour Coverage	One Unit	Two Units	One Unit	Two Units	One Unit	Two Units	One Unit	Two Units
Employee	3.23	3.98	6.46	7.96	7.00	8.63	14.00	17.25
Employee/Spouse	5.71	7.09	11.42	14.19	12.38	15.38	24.75	30.75
Employee/Child	4.96	6.23	9.92	12.46	10.75	13.50	21.50	27.00
Family	7.44	9.34	14.88	18.69	16.13	20.25	32.25	40.50
Wellness Rider								
Employee	0.69		1.38		1.50		3.00	
Employee/Spouse	1.38		2.77		3.00		6.00	
Employee/Child	1.38		2.77		3.00		6.00	
Family	2.08		4.15		4.50		9.00	

Form HPACC 2010NOC Accident Policy Rate Schedule

	Weekly Premium		Bi-Weekly Premium		Semi-Monthly Premium		Monthly Premium	
Off-the-Job Only	One Unit	Two Units	One Unit	Two Units	One Unit	Two Units	One Unit	Two Units
Employee	2.60	3.11	5.19	6.23	5.63	6.75	11.25	13.50
Employee/Spouse	4.79	5.94	9.57	11.88	10.38	12.88	20.75	25.75
Employee/Child	4.33	5.36	8.65	10.73	9.38	11.63	18.75	23.25
Family	6.52	8.19	13.03	16.38	14.13	17.75	28.25	35.50
Wellness Rider								
Employee	0.69		1.38		1.50		3.00	
Employee/Spouse	1.38		2.77		3.00		6.00	
Employee/Child	1.38		2.77		3.00		6.00	
Family	2.08		4.15		4.50		9.00	

SERFF Tracking Number:	*CEUL-128329220*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*HPACC2010*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*HPACC2010*		
Project Name/Number:	*HPACC2010/HPACC2010*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/04/2012

Comments:
N/A
Attachment:
readability signed.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	05/04/2012

Comments:
Application is also attached under Form Schedule.
Attachment:
C-HPACC-AP.pdf

		Item Status:	Status Date:
Satisfied - Item:	Health - Actuarial Justification	Approved-Closed	05/04/2012

Comments:
N/A
Attachments:
Actmem CUL Acc Exp HPACC2010-24.pdf
Actmem CUL Acc Exp HPACC2010NOC.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	05/04/2012

Comments:
Outlines of Coverage are also under the forms tab in case they should be attached there. Please let us know if they should be removed.
Attachments:
HPACC2010-24-OC-2.pdf

SERFF Tracking Number:	*CEUL-128329220*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*HPACC2010*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*HPACC2010*		
Project Name/Number:	*HPACC2010/HPACC2010*		

HPACC2010-NOC-OC-2.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability	Approved-Closed	05/04/2012

Comments:

n/a

Attachment:

Statement of Variables.pdf

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer: Central United Life Insurance Company
10700 Northwest Freeway
Houston, TX 77092

I hereby certify that the following scores are true:

Form Name	Form Number	Flesch Score	Number of Sentences	Number of Words	Number of Syllables	Type Size of Text
24 Hour Accident Expense Policy	HPACC2010-24-2	60.1	173	3,145	4,178	10 pt leaded
Non-Occupational Accident Expense Policy	HPACC2010-NOC-2	59.9	206	4,080	4,229	10 pt leaded
Wellness Rider	HRWEL2010	58.76	19	289	503	10 pt leaded

Signature of an Officer of the Insurer 

Name (Print) Mary Lou Rainey

Title Secretary

Date September 9, 2011

CENTRAL UNITED LIFE INSURANCE COMPANY

10700 Northwest Freeway, Houston, Texas 77092

Application for: ❑ 24-Hour ❑ Off-the-Job Accident Expense Policy

Requested Effective Date: _____

PART 1 - GENERAL INFORMATION

1. PERSONS TO BE COVERED

Name (Please PRINT Full Name)	Relationship	Gender	Date of Birth	Age	Height Ft. In.	Weight Lbs.	Social Security Number
1.	Applicant						- -
2.	Spouse						- -
3.	Child						- -
4.	Child						- -
5.	Child						- -

2. APPLICANT'S HOME ADDRESS

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Email Address: _____

3. PREMIUM PAYOR ADDRESS (if different than Applicant)

Premium Payor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

4. EMPLOYMENT INFORMATION (All adult applicants)

Employer's Name: _____

Occupation/Duties: _____

Spouse's Employer's Name (if applying): _____

Spouse's Occupation/Duties: _____

5. BENEFIT INFORMATION:

Monthly Premium: $ _____

Benefit Amount: ❑ 1.0 Unit ❑ 2.0 Units

Plan Type: ❑ Individual ❑ Individual & Spouse ❑ Single Parent ❑ Family

Billing Method: ❑ Monthly Bank Draft ❑ Direct Bill ❑ List Bill

Billing Mode: ❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

6. OPTIONAL RIDER:

Annual Wellness Benefit Rider Yes ❑ No ❑

Premium: $ _____

7. BENEFICIARY

Name: _____

Relationship: _____

8. PRIMARY PHYSICIAN

Name: _____

Address: _____

Phone: _____

PART 2 - REPRESENTATION & QUESTIONS OF THE APPLICANT

		YES	NO
1.	Are all persons to be insured to the best of your knowledge and belief in good health and free from physical impairment or abnormality?	❑	❑
2a.	Is any person to be insured engaged in any hazardous sports or activities including racing, but not limited to parachuting, rodeo riding, motorcycling, mountain climbing, scuba diving or intend to do so?	❑	❑
2b.	Is any person to be insured a member/participant in a semi-professional or professional sport?	❑	❑
3a.	Have you had a driver's license suspended or revoked within the past 3 years?	❑	❑
3b.	Have you had a DWI or DUI within the past 3 years?	❑	❑
3c.	Is any person to be insured currently under treatment or has any person to be insured been under treatment for drug or alcohol abuse in the past 3 years?	❑	❑
4.	Are all persons to be insured ages 19 to 25 years old enrolled as a full time student in an accredited school or college?	❑	❑
5.	Is there any other health, accident or disability insurance in force on the proposed insured?	❑	❑
6.	Will the insurance applied for replace or change any existing insurance?	❑	❑

If YES, give name of Company and type of insurance: _____

If Bank Draft Authorization, ATTACH VOIDED CHECK HERE and sign authorization at right.

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Central United Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original. Requested Draft Date: _____

_____ X _____

Date — Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ (Name) I hereby authorize _____ (Name of Employer)

to deduct from my salary and pay to Central United Life Insurance Company, Houston, Texas, the monthly deposits as set forth below. Beginning with the month of _____ (Month), 20 _____ $ _____ each month.

_____ (Signature of Employee) _____ (Date)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

A. I hereby authorize and request any physician, hospital, dentist, pharmacy, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Central United Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in the circumstances permitted by state and federal law.

B. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer, or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Central United Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy.

C. Central United Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply.

D. This authorization will be valid from the date signed for a period of twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I understand that revocation of this authorization may result in the application being declined and the policy may not be issued.

E. I authorize Central United Life Insurance Company to obtain an investigative consumer report on me.

Dated: _____ Dated at: _____

Signed X _____ (Signature of Proposed Insured) Signed X _____ (Signature of Spouse)

APPLICANT'S STATEMENT

I hereby apply to Central United Life Insurance Company for a policy to be issued in reliance on my written answers to the foregoing questions. I understand that: (a) the policy of insurance I am now applying for will be issued solely upon the written answers to questions and information asked for in this application; (b) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance; and (d) no change to the policy will be valid until approved by an officer of the Company which must be noted on or attached to the policy. I have read, or had read to me, the completed application and realize policy issuance is based upon statements and answers provided herein and they are complete and true to the best of my knowledge and belief. I acknowledge I have received an Outline of Coverage for the policy applied for.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact or material thereto commits a fraudulent insurance act, which may be a crime as determined by a court of law.

Dated at _____ (City, State & Zip) on _____ (Month & Day) 20 _____ .

Signature of Applicant: _____ Signature of Spouse: _____

AGENT'S STATEMENT

I Certify: 1) That any information recorded by me is true and correct to the best of my knowledge and belief. 2) I have given an outline of coverage for the policy applied for to the Applicant. 3) This ❑ does ❑ does not replace other insurance.

Dated _____ (City, State & Zip) on _____ (Month & Day) 20 _____ .

_____ (Agent Name (Print)) _____ (Agent Signature) _____ (Agent Number)

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.

CENTRAL UNITED LIFE INSURANCE COMPANY
a stock company
10700 Northwest Freeway
Houston, Texas 77092
Customer Service 800-669-9030

24 HOUR ACCIDENT EXPENSE POLICY FORM HPACC2010-24-2

REQUIRED OUTLINE OF COVERAGE

A. READ YOUR POLICY CAREFULLY! This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**

B. This Accident plan provides accidental death, dismemberment and medical expense benefits for the Insured Person(s), spouse and covered children with coterminous benefit and premium periods to age 70. Coverage is provided for the benefits described in the BENEFITS section below. The benefits described may be limited as outlined in the EXCLUSIONS section. The policy will pay the following benefits for a covered injury per unit unless otherwise noted. A maximum of 2 units may be purchased.

C. BENEFITS

Accidental Death Benefit (Principal Sum): Shown on the Policy Schedule page.

Common Carrier: If insured suffers a covered accidental death as a fare-paying passenger on a common carrier operating on a regularly scheduled basis such as a plane, bus, or train, benefit will be double the Accidental Death Benefit.

Burn. We will pay the applicable amount listed below if any Insured Person receives burns as the result of a Covered Accident which are treated by a Physician within 72 hours after the Covered Accident. We will pay only one benefit amount per Covered Accident.

We will pay 25% of the applicable Burn Benefit if any Insured Person receives a skin graft for a burn for which a benefit was paid under the Burn Benefit of this policy. This benefit will be payable only once per Covered Accident.

		Insured
Spouse/Child		
Second degree burns which cover at least 36% of the body surface	$ 375	$ 150
Third degree burns which cover at least 1% of the body surface		
but less than 20% of the body surface	$ 750	$ 300
Third degree burns which cover 20% or more of the body surface	$5,000	$2,000

Dislocated (separated joint). We will pay the applicable amount listed below if any Insured Person receives a dislocation as the result of a Covered Accident. As this list is not complete, We will pay a benefit similar to the dislocation suffered if not listed. A dislocation is a completely separated joint. In order for this benefit to payable for the joint involved, all of the following must occur:

- it must be diagnosed as a dislocation by a Physician within 90 days after the Covered Accident;
- the dislocation must require correction with anesthesia by a Physician; and

- the dislocation will be corrected by open (surgical) or closed (non-surgical) reduction.

If any Insured Person receives more than one dislocation in a Covered Accident and requires open or closed reduction, We will pay for all dislocations. However, We will pay no more than two times the amount for the joint involved which has the highest benefit amount.

If the dislocation requires reduction without anesthesia by a Physician, We will pay 25% of the amount listed for a closed reduction of the joint involved.

If a Physician diagnoses the dislocation as an incomplete dislocation, We will pay 25% of the amount listed for a closed reduction of the joint involved. An incomplete dislocation is a dislocation in which the joint is not completely separated.

We will pay this benefit only for the first dislocation of a joint after the policy Issue Date. Subsequent dislocations of the same joint after the policy Issue Date will not be covered.

Joint	Closed Reduction	Open Reduction
Hip	$1,000	$2,000
Knee (except Patella)	500	1,000
Ankle	400	800
Bone or bones of the foot (other than toes)	400	800
Collarbone (Sternoclavicular)	250	500
Lower Jaw	150	300
Shoulder (Glenohumeral)	150	300
Elbow	150	300
Wrist	150	300
Bone or bones of the hand (other than fingers)	150	300
Collarbone (Acromioclavicular and separation)	50	100
One toe or finger	50	100

Emergency Dental Work. We will pay the applicable amount listed below for dental work required by an Insured Person as the result of Injuries received in a Covered Accident.

Any and all broken teeth repaired with crown(s) $150

Any and all broken teeth resulting in extraction(s) $ 50

Benefits are payable only once per Covered Accident, regardless of the number of teeth involved.

Fracture (broken bone). We will pay the applicable amount listed below if any Insured Person receives a fracture as the result of a Covered Accident. As this list is not complete, We will pay a benefit similar to the fracture suffered if not listed.

A fracture is a break in a bone which can be seen by X-ray. In order for this benefit to be payable for the bone involved, all of the following must occur:

it must be diagnosed as a fracture by a Physician within 90 days after the Covered Accident; and

the fracture must require open (surgical) or closed (non-surgical) reduction by a Physician.

The maximum benefit payable for all fractures as the result of a Covered Accident is equal to two times the amount of the fracture with the highest benefit amount.

If a Physician diagnoses the fracture as a chip fracture, We will pay 25% of the amount listed for the closed reduction for the bone involved. A chip fracture is a fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

Bone	Closed Reduction	Open Reduction
Skull (except bones of face or nose)		
Depressed skull fracture	$1,250	$2,500
Simple non-depressed skull fracture	$ 500	$1,000
Hip, thigh (Femur)	$ 750	$1,500
Vertebrae, body of (excluding Vertebral Processes)	$ 400	$ 800
Pelvis (includes Ilium, Ischium, Pubis, Acetabulem except Coccyx)	$ 400	$ 800
Leg (Tibia and/or Fibula)	$ 400	$ 800
Bones of face or nose (except Mandible or Maxilla)	$ 175	$ 350
Upper jaw, Maxilla (except Alveolar Process)	$ 175	$ 350
Upper arm between elbow and shoulder (Humerus)	$ 175	$ 350
Lower jaw, Mandible (except Alveolar Process)	$ 150	$ 300
Shoulder blade (Scapula), collar bone (Clavicle, Sternum)	$ 150	$ 300
Vertebral Processes	$ 150	$ 300
Forearm (radius and/or Ulna)	$ 150	$ 300
Knee cap (Patella)	$ 150	$ 300
Hand, foot (except fingers, toes)	$ 150	$ 300
Ankle, wrist	$ 150	$ 300
Rib	$ 125	$ 250
Coccyx	$ 100	$ 200
Finger, toe	$ 25	$ 50

Hospital Admission. We will pay $500 if any Insured Person is Confined to a Hospital as the result of Injuries received in a Covered Accident. The Insured Person must be Confined within 180 days after the Covered Accident. This benefit will not be paid for: Emergency Room treatment; outpatient treatment; or a stay of less than 20 hours. This amount will be paid once per Covered Accident.

Hospital Confinement. We will pay $100 per day for up to 90 days per Covered Accident if any Insured Person is Confined in a Hospital or Hospital Sub-Acute Intensive Care Unit as the result of Injuries received in a Covered Accident. The Insured Person must become Confined in a Hospital or a Hospital Sub-Acute Intensive Care Unit within 180 days after the Covered Accident. We will pay benefits for only one Hospital Confinement at a time even if it is caused by more than one Covered Accident. We will not pay this benefit for: Emergency Room treatment; outpatient treatment; or a stay of less than 20 hours.

Hospital Intensive Care Unit Confinement. We will pay $200 per day for up to 15 days per Covered Accident if any Insured Person is Confined to a Hospital Intensive Care Unit as the result of Injuries received in a Covered Accident. The Confinement in a Hospital Intensive Care Unit must begin within 30 days after the Covered Accident.

If any Insured Person is Confined to a Hospital Intensive Care Unit that does not meet the definition in this policy of a Hospital Intensive Care Unit, We will pay the Hospital Confinement Benefit. The Hospital Intensive Care Unit Confinement Benefit and the Hospital Confinement Benefit will not be paid concurrently. If any Insured Person is Confined in a Hospital Intensive Care Unit for more than 15 days, the Hospital Confinement Benefit will begin on the 16th day. The total amount payable per Covered Accident will not exceed 90 days for Hospital Confinement and 15 days for Hospital Intensive Care Unit Confinement.

Knee Cartilage – Torn. We will pay $500, reduced by any benefit paid for arthroscopic surgery previously performed, if any Insured Person receives a torn knee cartilage (meniscus) as the result of a Covered Accident. For this benefit to be paid, all of the following must occur:

- it must be treated by a Physician within 60 days after the Covered Accident; and
- it must be repaired through surgery by a Physician within 180 days after the Covered Accident.

If exploratory arthroscopic surgery is performed within 180 days of the Covered Accident and no repair is done, or if the cartilage is shaved (debridement), We will pay $100.

Laceration. We will pay the applicable amount listed below if any Insured Person receives a laceration as the result of a Covered Accident. The laceration must be repaired by a Physician within 72 hours after the Covered Accident. The amount We will pay is based on the total length of all lacerations received in any one Covered Accident which require repair. If the laceration is severe enough to require stitches but the Physician chooses to repair it in another way, We will pay it as a laceration repaired with stitches.

Total of all lacerations is not more than three inches (7.6 cm) long and repaired by stitches,

staples or glue $ 50

Total of all lacerations is greater than three and not more than five inches (7.6 cm to 12.5 cm)

long and repaired by stitches, staples or glue $200

Total of all lacerations is more than five inches (12.5 cm) long and repaired by stitches,

staples or glue $400

If any Insured Person receives a laceration on a finger, toe, hand, foot or eye and later loses that finger, toe, hand, foot or eye as the result of the same Covered Accident, We will subtract the amount We paid under the Laceration Benefit from the Loss of Finger, Toe, Hand, Foot or Sight of an Eye Benefit.

Loss of Finger, Toe, Hand, Foot or Sight of an Eye. We will pay the applicable amount listed below for loss received as the result of a Covered Accident and in which loss occurs within 90 days after the Covered Accident.

	Insured	Spouse/Child
Loss of both hands, or both feet, or the sight of both eyes, or any combination of two or more listed above	$15,000	$10,000
Loss of one hand, or one foot, or sight of one eye	$ 7,500	$ 5,000
Loss of two or more fingers, or two or more toes, or any combination of two or more listed above	$ 1,500	$ 1,000
Loss of one finger or one toe	$ 750	$ 500

“Loss of a hand” means that the hand is cut off through or above the wrist joint or the use of the hand is medically determined to be permanently lost. “Loss of a foot” means that the foot is cut off through or above the ankle joint or the use of the foot is medically determined to be permanently lost. “Loss of a finger” means that the finger is cut off at the joint proximate to the first interphalangeal joint where it is attached to the hand. “Loss of a toe” means that the toe is cut off at the joint proximate to the first interphalangeal joint where it is attached to the foot. “Loss of sight of an eye” means that at least 80% of vision is permanently lost.

If the Insured Person loses a finger or toe and later loses a hand or foot within 90 days on the same side of the body as the result of the same Covered Accident, We will subtract the amount paid for the loss of a finger or toe from the Loss of Finger, Toe, Hand, Foot or Sight of an Eye Benefit.

Only the highest single benefit will be payable per Covered Accident. Benefits will be paid only once per Covered Accident. If death and Loss of Finger, Toe, Hand, Foot or Sight of an Eye result from the same Covered Accident, only the Accidental Death Benefit will be paid.

Major Diagnostic Exams. We will pay $100 per Calendar Year if an Insured Person requires one of the following exams for Injuries received as the result of a Covered Accident:

angiogram; CT (computerized tomography) scan; CTA (computerized tomography angiogram) scan; MRI (magnetic resonance imaging); MRA (magnetic resonance angiogram); or EEG (electroencephalogram).

The following benefits are the Maximum for the policy regardless of units purchased:

Air Ambulance. We will pay $500 if a licensed professional air ambulance company transports any Insured Person by air to or from a Hospital or between medical facilities, where treatment for Injuries is provided as the result of a Covered Accident. The air ambulance transportation must occur within 48 hours after the Covered Accident. This amount will be paid once per Covered Accident.

Ambulance. We will pay $100 if a licensed professional ambulance company transports any Insured Person by ground transportation to or from a Hospital or between medical facilities, where treatment for Injuries is provided for Injuries resulting from a Covered Accident. The ambulance transportation must occur within 90 days from the Covered Accident. This amount will be paid once per Covered Accident.

Appliance. We will pay $100 if any Insured Person is injured as the result of a Covered Accident and a Physician prescribes the use of a medical appliance as an aid in personal locomotion or mobility. Crutches, braces, walkers and wheelchairs are examples of medical appliances. The use of an appliance must be prescribed within 90 days after the Covered Accident. This amount will be paid once per Covered Accident.

Blood/Plasma/Platelets. We will pay $300 if the primary Insured Person ($200 if the Spouse/Dependent Child) is injured as the result of a Covered Accident and requires the transfusion, administration, cross-matching, typing and processing of blood, blood plasma or platelets as the result of the injury. The blood, blood plasma or platelets must be administered within 90 days after the Covered Accident. This amount will be paid once per Covered Accident.

Emergency Room Treatment. We will pay $200 if any Insured Person is injured as the result of a Covered Accident and the Insured Person requires examination and treatment by a Physician in an Emergency Room within 72 hours after the Covered Accident. This amount will be paid once per Covered Accident.

Eye Injury. We will pay $200 if any Insured Person receives an eye Injury as the result of a Covered Accident. The eye Injury must require surgery or the removal of a foreign object by a Physician within 90 days after the Covered Accident. This amount will be paid once per Covered Accident. An examination with anesthesia will not be considered surgery.

Gunshot Wound. We will pay $500 if the primary Insured Person is injured by one or more gunshot wounds and did not intentionally shoot themselves. The wound(s) must be caused by a shot from a conventional firearm. A conventional firearm is a weapon which fires a shot (bullet) by gun powder or compressed gas. The wound(s) must require treatment by a Physician, including Confinement within 24 hours and surgery within 72 hours after the injury.

Lodging. We will pay $100 per night for one motel/hotel room, for up to 30 days per Covered Accident, if a companion accompanies the Insured Person. This benefit is payable only for motel/hotel stays during the period of time the Insured Person is Confined to the Hospital. In order for this benefit to be payable, the Hospital in which the Insured Person is Confined must be located more than 100 miles from the residence of the Insured Person.

Physician's Office/Urgent Care. We will pay $50 if any Insured Person receives treatment and/or advice by a Physician in their office or an Urgent Care Facility for Injuries as the result of a Covered Accident. The treatment must occur within 60 days after the Covered Accident and the services provided must be the result of a Covered Accident and not for routine examinations or preventative testing. This amount will be paid once per Covered Accident.

Prosthetic Device/Artificial Limb. We will pay the applicable amount listed below for a prosthetic device/artificial limb which is prescribed by a Physician for functional use when the Insured Person loses a hand, foot or sight of an eye due to a Covered Accident. The prosthetic device/artificial limb must be received within one year of the Covered Accident. This amount will be paid once per Covered Accident.

One prosthetic device or artificial limb	$ 500
More than one prosthetic device or artificial limb	$ 1,000

This benefit will not be paid for: hearing aids; dental aids, including false teeth; eye glasses; cosmetic prosthesis such as wigs; or joint replacement such as an artificial hip or knee.

Ruptured Disc. We will pay $400 for any and all ruptured discs in the spine suffered by an Insured Person as the result of a Covered Accident. For this benefit to be paid, all of the following must occur.

- the ruptured disc(s) must be treated by a Physician within 60 days after the Covered Accident; and
- the ruptured disc(s) must be repaired through surgery by a Physician within one year after the Covered Accident.

This amount will be paid once per Covered Accident.

Surgery. We will pay $1,000 if any Insured Person undergoes open abdominal or thoracic surgery, within 72 hours after the Covered Accident, to repair internal Injuries received as a result of the Covered Accident. For open abdominal or thoracic exploratory surgery without repair, We will pay a benefit of $100. For exploratory or other surgery without repair, We will pay a benefit of $100. This amount will be paid once per Covered Accident. Hernia repair will not be covered.

Tendon/Ligament/Rotator Cuff. We will pay $500 for the surgical repair of any and all torn, ruptured or severed tendon, ligament or rotator cuff which an Insured Person suffered as the result of a Covered Accident. The surgery must be performed by a Physician within 90 days after the Covered Accident.

If exploratory arthroscopic surgery is performed and no repair is done, We will pay a benefit of $100.

If any Insured Person receives a fracture or a dislocation and tears, ruptures or severs a tendon/ligament/rotator cuff in the same Covered Accident, only one benefit will be paid. We will pay the larger of the Tendon/Ligament/Rotator Cuff Benefit, the Fracture Benefit or the Dislocation Benefit.

Transportation. We will pay $300 per round trip if any Insured Person must travel more than 100 miles round trip from their residence to receive treatment and be confined in a Hospital for Injuries received as the result of a Covered Accident. Treatment must be prescribed by a Physician and not available locally. This benefit is payable for up to three round trips per Covered Accident. This benefit is not payable for transportation by ambulance or air ambulance.

D. EXCLUSIONS

We will not pay benefits for losses that are caused by or are the result of any Insured Person(s):

1) operating, learning to operate, or serving as a crew member of any aircraft;
2) engaging in hang-gliding, hot air ballooning, bungee jumping, parachuting, scuba diving, sail gliding, parasailing, parakiting or any similar activities;
3) riding in or driving any motor-driven vehicle in a race, stunt show or speed test;

4) officiating, coaching, practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received;

5) who has any sickness or condition caused by a sickness independent of the Covered Accident, including physical or mental infirmity. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by any injury;

6) being exposed to war or any act of war, declared or undeclared;

7) actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;

8) suffering from mental or nervous disorders;

9) being addicted to drugs or suffering from alcoholism;

10) being under the influence of an excitant, depressant, hallucinogen, narcotic, or any other drug or intoxicant, including those prescribed by a Physician that are misused;

11) receiving Injuries caused directly or indirectly while under the influence of a controlled substance or by intoxication as defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred;

12) having cosmetic surgery or other elective procedures that are not medically necessary;

13) having dental treatment except as the result of an Injury;

14) having a hernia;

15) participating in or attempting to commit a felony;

16) being incarcerated in a penal institution or government detention facility;

17) driving any taxi for wage, compensation or profit;

18) engaging in an illegal activity or occupation;

19) self-inflicting an Injury intentionally; or

20) committing or attempting to commit suicide, while sane or insane;

E. RENEWABILITY – This Policy is Guaranteed Renewable to age 70. That means as long as You pay the Renewal Premiums when due, subject to a 31-day Grace Period, We cannot cancel or change Your Policy.

F. OPTIONAL BENEFIT RIDERS (Available with additional premium)

Annual Wellness Benefit Rider HRWEL2010: We will pay $60 once each Policy year if You, Your Spouse or any one family member (Dependent) named in the Policy Schedule undergo any of the following examinations: an annual physical examination, dental exam, mammogram, Pap smear, eye examination, immunization, flexible sigmoidoscopies, PSA test, ultrasounds or blood screening test. Service must be under the supervision of, or recommended by, a Physician and received while Your Policy is in force. A charge must be incurred. All dependent children will be treated as one insured for this benefit. This policy must be in force for 12 months before this benefit is payable.

G. PREMIUMS. We reserve the right to change the Premium rates. If We do this, We can only do it to all Policies in Your class. We will give You 31 days notice if We change Premium rates.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.

CENTRAL UNITED LIFE INSURANCE COMPANY
a stock company
10700 Northwest Freeway
Houston, Texas 77092
Customer Service 800-669-9030
ACCIDENT EXPENSE POLICY HPACC2010-NOC-2
Limited Benefits for Accident While Off-the-Job.
It does not pay benefits for loss from injuries or sickness received while working for wage or profit.
REQUIRED OUTLINE OF COVERAGE

A. READ YOUR POLICY CAREFULLY! This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**

B. Accident plans provide accidental death, dismemberment and medical expense benefits for the Insured Person(s), spouse and covered children with coterminous benefit and premium periods to age 70. Coverage is provided for the benefits described in the BENEFITS section below. The benefits described may be limited as outlined in the EXCLUSIONS section. The policy will pay the following benefits for a covered injury per unit unless otherwise noted. A maximum of 2 units may be purchased.

C. BENEFITS Benefits will not be paid for injuries received while working for wage or profit.

Accidental Death Benefit (Principal Sum):

PRINCIPAL SUM - YOU	{Units of $25,000; Min. $25,000; Max. $50,000}
PRINCIPAL SUM – SPOUSE	{Units of $10,000; Min. $10,000; Max. $20,000}
PRINCIPAL SUM - EACH CHILD	{Units of $ 5,000; Min. $ 5,000; Max. $10,000}

Common Carrier: If insured suffers a covered accidental death as a fare-paying passenger on a common carrier operating on a regularly scheduled basis such as a plane, bus or train, benefit will be double the Accidental Death Benefit.

Burn. We will pay the applicable amount listed below if any Insured Person receives burns as the result of a Covered Accident which are treated by a Physician within 72 hours after the Covered Accident. We will pay only one benefit amount per Covered Accident.

We will pay 25% of the applicable Burn Benefit if any Insured Person receives a skin graft for a burn for which a benefit was paid under the Burn Benefit of this policy. This benefit will be payable only once per Covered Accident.

	Insured	Spouse/Child
Second degree burns which cover at least 36% of the body surface	$ 375	$ 150
Third degree burns which cover at least 1% of the body surface but less than 20% of the body surface	$ 750	$ 300
Third degree burns which cover 20% or more of the body surface	$5,000	$2,000

Dislocated (separated joint). We will pay the applicable amount listed below if any Insured Person receives a dislocation as the result of a Covered Accident. As this list is not complete, We will pay a benefit similar to the dislocation suffered if not listed. A dislocation is a completely separated joint. In order for this benefit to payable for the joint involved, all of the following must occur:

- it must be diagnosed as a dislocation by a Physician within 90 days after the Covered Accident;

- the dislocation must require correction with anesthesia by a Physician; and
- the dislocation will be corrected by open (surgical) or closed (non-surgical) reduction.

If any Insured Person receives more than one dislocation in a Covered Accident and requires open or closed reduction, We will pay for all dislocations. However, We will pay no more than two times the amount for the joint involved which has the highest benefit amount.

If the dislocation requires reduction without anesthesia by a Physician, We will pay 25% of the amount listed for a closed reduction of the joint involved.

If a Physician diagnoses the dislocation as an incomplete dislocation, We will pay 25% of the amount listed for a closed reduction of the joint involved. An incomplete dislocation is a dislocation in which the joint is not completely separated.

We will pay this benefit only for the first dislocation of a joint after the policy Issue Date. Subsequent dislocations of the same joint after the policy Issue Date will not be covered.

Joint	Closed Reduction	Open Reduction
Hip	$1,000	$2,000
Knee (except Patella)	500	1,000
Ankle	400	800
Bone or bones of the foot (other than toes)	400	800
Collarbone (Sternoclavicular)	250	500
Lower Jaw	150	300
Shoulder (Glenohumeral)	150	300
Elbow	150	300
Wrist	150	300
Bone or bones of the hand (other than fingers)	150	300
Collarbone (Acromioclavicular and separation)	50	100
One toe or finger	50	100

Emergency Dental Work. We will pay the applicable amount listed below for dental work required by an Insured Person as the result of Injuries received in a Covered Accident.

Any and all broken teeth repaired with crown(s) $150

Any and all broken teeth resulting in extraction(s) $ 50

Benefits are payable only once per Covered Accident, regardless of the number of teeth involved.

l. Fracture (broken bone). We will pay the applicable amount listed below if any Insured Person receives a fracture as the result of a Covered Accident. As this list is not complete, We will pay a benefit similar to the fracture suffered if not listed.

A fracture is a break in a bone which can be seen by X-ray. In order for this benefit to be payable for the bone involved, all of the following must occur:

- it must be diagnosed as a fracture by a Physician within 90 days after the Covered Accident; and

- the fracture must require open (surgical) or closed (non-surgical) reduction by a Physician.

The maximum benefit payable for all fractures as the result of a Covered Accident is equal to two times the amount of the fracture with the highest benefit amount.

If a Physician diagnoses the fracture as a chip fracture, We will pay 25% of the amount listed for the closed reduction for the bone involved. A chip fracture is a fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

Bone	Closed Reduction	Open Reduction
Skull (except bones of face or nose)		
Depressed skull fracture	$1,250	$2,500
Simple non-depressed skull fracture	$ 500	$1,000
Hip, thigh (Femur)	$ 750	$1,500
Vertebrae, body of (excluding Vertebral Processes)	$ 400	$ 800
Pelvis (includes Ilium, Ischium, Pubis, Acetabulem except Coccyx)	$ 400	$ 800
Leg (Tibia and/or Fibula)	$ 400	$ 800
Bones of face or nose (except Mandible or Maxilla)	$ 175	$ 350
Upper jaw, Maxilla (except Alveolar Process)	$ 175	$ 350
Upper arm between elbow and shoulder (Humerus)	$ 175	$ 350
Lower jaw, Mandible (except Alveolar Process)	$ 150	$ 300
Shoulder blade (Scapula), collar bone (Clavicle, Sternum)	$ 150	$ 300
Vertebral Processes	$ 150	$ 300
Forearm (radius and/or Ulna)	$ 150	$ 300
Knee cap (Patella)	$ 150	$ 300
Hand, foot (except fingers, toes)	$ 150	$ 300
Ankle, wrist	$ 150	$ 300
Rib	$ 125	$ 250
Coccyx	$ 100	$ 200
Finger, toe	$ 25	$ 50

Hospital Admission. We will pay $500 if any Insured Person is Confined to a Hospital as the result of Injuries received in a Covered Accident. The Insured Person must be Confined within 180 days after the Covered Accident. This benefit will not be paid for: Emergency Room treatment; outpatient treatment; or a stay of less than 20 hours. This amount will be paid once per Covered Accident.

Hospital Confinement. We will pay $100 per day for up to 90 days per Covered Accident if any Insured Person is Confined in a Hospital or Hospital Sub-Acute Intensive Care Unit as the result of Injuries received in a Covered Accident. The Insured Person must become Confined in a Hospital or a Hospital Sub-Acute

Intensive Care Unit within 180 days after the Covered Accident. We will pay benefits for only one Hospital Confinement at a time even if it is caused by more than one Covered Accident. We will not pay this benefit for: Emergency Room treatment; outpatient treatment; or a stay of less than 20 hours.

Hospital Intensive Care Unit Confinement. We will pay $200 per day for up to 15 days per Covered Accident if any Insured Person is Confined to a Hospital Intensive Care Unit as the result of Injuries received in a Covered Accident. The Confinement in a Hospital Intensive Care Unit must begin within 30 days after the Covered Accident.

If any Insured Person is Confined to a Hospital Intensive Care Unit that does not meet the definition in this policy of a Hospital Intensive Care Unit, We will pay the Hospital Confinement Benefit. The Hospital Intensive Care Unit Confinement Benefit and the Hospital Confinement Benefit will not be paid concurrently. If any Insured Person is Confined in a Hospital Intensive Care Unit for more than 15 days, the Hospital Confinement Benefit will begin on the 16th day. The total amount payable per Covered Accident will not exceed 90 days for Hospital Confinement and 15 days for Hospital Intensive Care Unit Confinement.

Knee Cartilage – Torn. We will pay $500, reduced by any benefit paid for arthroscopic surgery previously performed, if any Insured Person receives a torn knee cartilage (meniscus) as the result of a Covered Accident. For this benefit to be paid, all of the following must occur:

- it must be treated by a Physician within 60 days after the Covered Accident; and
- it must be repaired through surgery by a Physician within 180 days after the Covered Accident.

If exploratory arthroscopic surgery is performed within 180 days of the Covered Accident and no repair is done, or if the cartilage is shaved (debridement), We will pay $100.

Laceration. We will pay the applicable amount listed below if any Insured Person receives a laceration as the result of a Covered Accident. The laceration must be repaired by a Physician within 72 hours after the Covered Accident. The amount We will pay is based on the total length of all lacerations received in any one Covered Accident which require repair. If the laceration is severe enough to require stitches but the Physician chooses to repair it in another way, We will pay it as a laceration repaired with stitches.

Total of all lacerations is not more than three inches (7.6 cm) long and repaired by stitches,

staples or glue $ 50

Total of all lacerations is greater than three and not more than five inches (7.6 cm to 12.5 cm)

long and repaired by stitches, staples or glue $200

Total of all lacerations is more than five inches (12.5 cm) long and repaired by stitches,

staples or glue $400

If any Insured Person receives a laceration on a finger, toe, hand, foot or eye and later loses that finger, toe, hand, foot or eye as the result of the same Covered Accident, We will subtract the amount We paid under the Laceration Benefit from the Loss of Finger, Toe, Hand, Foot or Sight of an Eye Benefit.

Loss of Finger, Toe, Hand, Foot or Sight of an Eye. We will pay the applicable amount listed below for loss received as the result of a Covered Accident and in which loss occurs within 90 days after the Covered Accident.

	Insured	Spouse/Child
Loss of both hands, or both feet, or the sight of both eyes, or any combination of two or more listed above	$15,000	$10,000
Loss of one hand, or one foot, or sight of one eye	$ 7,500	$ 5,000
Loss of two or more fingers, or two or more toes, or any		

combination of two or more listed above	$ 1,500	$ 1,000
Loss of one finger or one toe	$ 750	$ 500

"Loss of a hand" means that the hand is cut off through or above the wrist joint or the use of the hand is medically determined to be permanently lost. "Loss of a foot" means that the foot is cut off through or above the ankle joint or the use of the foot is medically determined to be permanently lost. "Loss of a finger" means that the finger is cut off at the joint proximate to the first interphalangeal joint where it is attached to the hand. "Loss of a toe" means that the toe is cut off at the joint proximate to the first interphalangeal joint where it is attached to the foot. "Loss of sight of an eye" means that at least 80% of vision is permanently lost.

If the Insured Person loses a finger or toe and later loses a hand or foot within 90 days on the same side of the body as the result of the same Covered Accident, We will subtract the amount paid for the loss of a finger or toe from the Loss of Finger, Toe, Hand, Foot or Sight of an Eye Benefit.

Only the highest single benefit will be payable per Covered Accident. Benefits will be paid only once per Covered Accident. If death and Loss of Finger, Toe, Hand, Foot or Sight of an Eye result from the same Covered Accident, only the Accidental Death Benefit will be paid.

Major Diagnostic Exams. We will pay $100 per Calendar Year if an Insured Person requires one of the following exams for Injuries received as the result of a Covered Accident:

- angiogram; CT (computerized tomography) scan; CTA (computerized tomography angiogram) scan; MRI (magnetic resonance imaging); MRA (magnetic resonance angiogram); or EEG (electroencephalogram).

The following benefits are the Maximum for the policy regardless of units purchased:

Air Ambulance. We will pay $500 if a licensed professional air ambulance company transports any Insured Person by air to or from a Hospital or between medical facilities, where treatment for Injuries is provided as the result of a Covered Accident. The air ambulance transportation must occur within 48 hours after the Covered Accident. This amount will be paid once per Covered Accident.

Ambulance. We will pay $100 if a licensed professional ambulance company transports any Insured Person by ground transportation to or from a Hospital or between medical facilities, where treatment for Injuries is provided for Injuries resulting from a Covered Accident. The ambulance transportation must occur within 90 days from the Covered Accident. This amount will be paid once per Covered Accident.

Appliance. We will pay $100 if any Insured Person is injured as the result of a Covered Accident and a Physician prescribes the use of a medical appliance as an aid in personal locomotion or mobility. Crutches, braces, walkers and wheelchairs are examples of medical appliances. The use of an appliance must be prescribed within 90 days after the Covered Accident. This amount will be paid once per Covered Accident.

Blood/Plasma/Platelets. We will pay $300 if the primary Insured Person ($200 if the Spouse/Dependent Child) is injured as the result of a Covered Accident and requires the transfusion, administration, cross-matching, typing and processing of blood, blood plasma or platelets as the result of the injury. The blood, blood plasma or platelets must be administered within 90 days after the Covered Accident. This amount will be paid once per Covered Accident.

Emergency Room Treatment. We will pay $200 if any Insured Person is injured as the result of a Covered Accident and the Insured Person requires examination and treatment by a Physician in an Emergency Room within 72 hours after the Covered Accident. This amount will be paid once per Covered Accident.

Eye Injury. We will pay $200 if any Insured Person receives an eye Injury as the result of a Covered Accident. The eye Injury must require surgery or the removal of a foreign object by a Physician within 90 days after the Covered Accident. This amount will be paid once per Covered Accident. An examination with anesthesia will not be considered surgery.

Gunshot Wound. We will pay $500 if the primary Insured Person is injured by one or more gunshot wounds and did not intentionally shoot themselves. The wound(s) must be caused by a shot from a conventional firearm. A conventional firearm is a weapon which fires a shot (bullet) by gun powder or compressed gas. The wound(s) must require treatment by a Physician, including Confinement within 24 hours and surgery within 72 hours after the injury.

Lodging. We will pay $100 per night for one motel/hotel room, for up to 30 days per Covered Accident, if a companion accompanies the Insured Person. This benefit is payable only for motel/hotel stays during the period of time the Insured Person is Confined to the Hospital. In order for this benefit to be payable, the Hospital in which the Insured Person is Confined must be located more than 100 miles from the residence of the Insured Person.

Physician's Office/Urgent Care. We will pay $50 if any Insured Person receives treatment and/or advice by a Physician in their office or an Urgent Care Facility for Injuries as the result of a Covered Accident. The treatment must occur within 60 days after the Covered Accident and the services provided must be the result of a Covered Accident and not for routine examinations or preventative testing. This amount will be paid once per Covered Accident.

Prosthetic Device/Artificial Limb. We will pay the applicable amount listed below for a prosthetic device/artificial limb which is prescribed by a Physician for functional use when the Insured Person loses a hand, foot or sight of an eye due to a Covered Accident. The prosthetic device/artificial limb must be received within one year of the Covered Accident. This amount will be paid once per Covered Accident.

One prosthetic device or artificial limb	$ 500
More than one prosthetic device or artificial limb	$ 1,000

This benefit will not be paid for: hearing aids; dental aids, including false teeth; eye glasses; cosmetic prosthesis such as wigs; or joint replacement such as an artificial hip or knee.

Ruptured Disc. We will pay $400 for any and all ruptured discs in the spine suffered by an Insured Person as the result of a Covered Accident. For this benefit to be paid, all of the following must occur.

- the ruptured disc(s) must be treated by a Physician within 60 days after the Covered Accident; and
- the ruptured disc(s) must be repaired through surgery by a Physician within one year after the Covered Accident.

This amount will be paid once per Covered Accident.

Surgery. We will pay $1,000 if any Insured Person undergoes open abdominal or thoracic surgery, within 72 hours after the Covered Accident, to repair internal Injuries received as a result of the Covered Accident. For open abdominal or thoracic exploratory surgery without repair, We will pay a benefit of $100. For exploratory or other surgery without repair, We will pay a benefit of $100. This amount will be paid once per Covered Accident. Hernia repair will not be covered.

Tendon/Ligament/Rotator Cuff. We will pay $500 for the surgical repair of any and all torn, ruptured or severed tendon, ligament or rotator cuff which an Insured Person suffered as the result of a Covered Accident. The surgery must be performed by a Physician within 90 days after the Covered Accident.

If exploratory arthroscopic surgery is performed and no repair is done, We will pay a benefit of $100.

If any Insured Person receives a fracture or a dislocation and tears, ruptures or severs a tendon/ligament/rotator cuff in the same Covered Accident, only one benefit will be paid. We will pay the larger of the Tendon/Ligament/Rotator Cuff Benefit, the Fracture Benefit or the Dislocation Benefit.

Transportation. We will pay $300 per round trip if any Insured Person must travel more than 100 miles round trip from their residence to receive treatment and be confined in a Hospital for Injuries received as the result of a Covered Accident. Treatment must be prescribed by a Physician and not available locally.

This benefit is payable for up to three round trips per Covered Accident. This benefit is not payable for transportation by ambulance or air ambulance.

D. EXCLUSIONS

We will not pay benefits for losses that are caused by or are the result of any Insured Person(s):

1) operating, learning to operate, or serving as a crew member of any aircraft;
2) engaging in hang-gliding, hot air ballooning, bungee jumping, parachuting, scuba diving, sail gliding, parasailing, parakiting or any similar activities;
3) riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
4) officiating, coaching, practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received;
5) who has any sickness or condition caused by a sickness independent of the Covered Accident, including physical or mental infirmity. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by any injury;
6) being exposed to war or any act of war, declared or undeclared;
7) actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;
8) suffering from mental or nervous disorders;
9) being addicted to drugs or suffering from alcoholism;
10) being under the influence of an excitant, depressant, hallucinogen, narcotic, or any other drug or intoxicant, including those prescribed by a Physician that are misused;
11) receiving Injuries caused directly or indirectly while under the influence of a controlled substance or by intoxication as defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred;
12) having cosmetic surgery or other elective procedures that are not medically necessary;
13) having dental treatment except as the result of an Injury;
14) having a hernia;
15) participating in or attempting to commit a felony;
16) being incarcerated in a penal institution or government detention facility;
17) driving any taxi for wage, compensation or profit;
18) engaging in an illegal activity or occupation;
19) self-inflicting an Injury intentionally; or
20) committing or attempting to commit suicide, while sane or insane;

E. RENEWABILITY – This Policy is Guaranteed Renewable to age 70. That means as long as You pay the Renewal Premiums when due, subject to a 31-day Grace Period, We cannot cancel or change Your Policy.

F. OPTIONAL BENEFIT RIDERS (Available with additional premium)

Annual Wellness Benefit Rider HRWEL2010: We will pay $60 once each Policy year if You, Your Spouse or any one family member (Dependent) named in the Policy Schedule undergo any of the following examinations: an annual physical examination, dental exam, mammogram, Pap smear, eye examination, immunization, flexible sigmoidoscopies, PSA test, ultrasounds or blood screening test. Service must be under the supervision of, or recommended by, a Physician and received while Your Policy is in force. A charge must be incurred. All dependent children will be treated as one insured for this benefit. This policy must be in force for 12 months before this benefit is payable.

G. PREMIUMS. We reserve the right to change the Premium rates. If We do this, We can only do it to all Policies in Your class. We will give You 31 days notice if We change Premium rates.

CENTRAL UNITED

Submission Type: New Product Filing
Form Number(s): HPACC2010-24-2, HPACC2010-NOC-2

To whom it may concern:

This letter is to serve as a statement of variables for the above referenced filing. Please note, there are two versions of our Accident Only product. One version offers the insured coverage while off-the-job, while the other offers coverage at all times.

Form Number: HPACC2010-24-2	Form Name: 24 Hour Accident Expense Policy
Bracketed Information	**Explanation**
Accidental Death Benefit Insured, Spouse, Child(ren)	The Accidental Death Benefit will vary based on the units purchased, limit 2 units.
Company Address, Phone Number, Officers	The Company will promptly notify the Department if the Company moves to a different location. Company officers may change.
Insured Name, Age, Policy Number, Effective Date, Initial Premium, Dependents, and Mode of Payment	Individual policyholder information will be populated here. Premium will be determined by the number of units purchased and underwriting.
Policy Form Number	State-specific form numbers will be populated here.
Rider: Form Name, Benefit Description, and Premium	The purchase of the rider is optional.

Form Number: HPACC2010-NOC-2	Form Name: Non-Occupational Accident Expense Policy
Bracketed Information	**Explanation**
Accidental Death Benefit Insured, Spouse, Child(ren)	The Accidental Death Benefit will vary based on the units purchased, limit 2 units.
Company Address, Phone Number, Officers	The Company will promptly notify the Department if the Company moves to a different location. Company officers may change.
Insured Name, Age, Policy Number, Effective Date, Initial Premium, Dependents, and Mode of Payment	Individual policyholder information will be populated here. Premium will be determined by the number of units purchased and underwriting.
Policy Form Number	State-specific form numbers will be populated here.
Rider: Form Name, Benefit Description, and Premium	The purchase of the rider is optional.

Central United Life Insurance Company appreciates the Department's time in reviewing this filing. If you have any questions, you may contact me by email at Rebecca.podowski@manhattanlife.com or by phone at 1-800-669-9030, extension 5271.

Sincerely,

Rebecca Kaufmann Podowski
Form Filing Analyst